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# **Managing boundaries in merger integration**

Derek O'Byrne

Submitted for the Award of

Doctor of Philosophy

at

Warwick Business School  
University of Warwick

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## Table of Contents

<b>1</b>	<b>INTRODUCTION TO THESIS .....</b>	<b>11</b>
1.1	INTRODUCTION .....	11
1.2	MERGER INTEGRATION AND BOUNDARIES.....	12
1.3	OBJECTIVES OF THE THESIS .....	14
1.4	IMPORTANCE OF THIS WORK.....	17
1.5	CONTRIBUTION OF THE RESEARCH .....	19
1.6	THE STRUCTURE OF THE THESIS .....	23
<b>2</b>	<b>DEVELOPING THEORY FROM THEORY: INTEGRATING M&amp;A AND BOUNDARY LITERATURE.....</b>	<b>25</b>
2.1	INTRODUCTION .....	25
2.2	THE NATURE OF BOUNDARIES .....	27
2.2.1	<i>Conceptualising Boundaries .....</i>	<i>28</i>
2.2.2	<i>Defining and Classifying Boundaries.....</i>	<i>35</i>
2.2.3	<i>Boundaries as Ever-shifting: Boundary Salience.....</i>	<i>37</i>
2.3	TOWARD A CONSTRUCT OF BOUNDARIES .....	39
2.3.1	<i>Physical Boundaries.....</i>	<i>40</i>
2.3.2	<i>Behavioural Boundaries.....</i>	<i>40</i>
2.3.3	<i>Cognitive Boundaries.....</i>	<i>41</i>
2.4	THE CONTEXT FOR M&A INTEGRATION .....	41
2.4.1	<i>Strategic Interdependence .....</i>	<i>42</i>
2.4.2	<i>Organisational Autonomy .....</i>	<i>43</i>
2.4.3	<i>Integration Approaches.....</i>	<i>43</i>
2.4.4	<i>The Level of Success in M&amp;A.....</i>	<i>45</i>
2.4.5	<i>A Working Definition of Success .....</i>	<i>47</i>
2.5	M&A INTEGRATION.....	48
2.5.1	<i>Procedural Integration.....</i>	<i>48</i>
2.5.2	<i>Physical Integration .....</i>	<i>49</i>
2.5.3	<i>Managerial and Sociocultural Integration.....</i>	<i>50</i>
2.5.4	<i>Task and Human Integration.....</i>	<i>51</i>
2.6	CHALLENGES IN POST-ACQUISITION INTEGRATION .....	52
2.6.1	<i>Pre-integration Factors Impinging on Integration Outcomes.....</i>	<i>52</i>
2.6.2	<i>Post-integration Factors Impinging on Integration Outcomes .....</i>	<i>57</i>
2.7	POWER AND POLITICS .....	64
2.7.1	<i>Mobilising Power and Politics in M&amp;As.....</i>	<i>66</i>
2.8	LEADERSHIP AND COMMUNICATION IN M&A INTEGRATION .....	67
2.9	MANAGING M&A INTEGRATION .....	72
2.9.1	<i>Contact and Awareness Building .....</i>	<i>73</i>
2.9.2	<i>Training and Behaviour Support.....</i>	<i>74</i>
2.9.3	<i>Building Vision for the New Organisation .....</i>	<i>75</i>
2.10	A FRAMEWORK FOR STUDYING BOUNDARIES IN M&AS .....	76
2.11	CONCLUSION .....	77
<b>3</b>	<b>METHODOLOGY .....</b>	<b>79</b>
3.1	INTRODUCTION .....	79
3.2	THE RESEARCH OBJECTIVES .....	80
3.3	THE NATURE OF THE WORLD AND THE UNDERSTANDING OF KNOWLEDGE.....	82
3.4	A FRAMEWORK FOR METHODOLOGY.....	85
3.5	THE USE OF CASE STUDIES IN THEORY DEVELOPMENT.....	86
3.6	ORGANISATION DEVELOPMENT AS A METHODOLOGY .....	89
3.6.1	<i>Systems Theory and Complexity.....</i>	<i>91</i>
3.6.2	<i>Collaborative Management Research .....</i>	<i>93</i>
3.6.3	<i>Organisation Development and Sustainable Learning.....</i>	<i>97</i>
3.7	CONDUCTING ACTION RESEARCH.....	99
3.7.1	<i>Stages in the Action Research Cycle .....</i>	<i>103</i>
3.8	THE ROLE OF THE ACTION RESEARCHER .....	105
3.9	THE NATURE OF THEORY.....	112

3.9.1	<i>Theory and the Complexity of Organisational Life: Seeing from the Inside</i> .....	114
3.9.2	<i>The Process of Theory Building</i> .....	116
3.10	ENSURING QUALITY IN THEORY DEVELOPMENT .....	122
3.10.1	<i>Outcome Validity</i> .....	123
3.10.2	<i>Process Validity</i> .....	124
3.10.3	<i>Democratic Validity</i> .....	124
3.10.4	<i>Catalytic Validity</i> .....	125
3.10.5	<i>Dialogic Validity</i> .....	125
3.11	CONCLUSION .....	127
4	<b>METHOD</b> .....	129
4.1	INTRODUCTION .....	129
4.1.1	<i>Determining Criteria for Selecting Organisations for Study</i> .....	130
4.1.2	<i>Selecting Two Studies</i> .....	133
4.2	THE FINANCIAL SERVICES STUDY .....	136
4.2.1	<i>Developing the Boundary Framework</i> .....	137
4.2.2	<i>The Case Context Data Collection Phase</i> .....	138
4.2.3	<i>Selecting the Branches for Study</i> .....	140
4.2.4	<i>Conducting the Research Interviews</i> .....	141
4.2.5	<i>Data Analysis for the Financial Services Study</i> .....	143
4.2.6	<i>Assessing Quality of the Research Findings in the Financial Study</i> .....	146
4.3	THE HOSPITAL STUDY .....	146
4.3.1	<i>Agreeing the Terms of Engagement</i> .....	148
4.3.2	<i>Agreeing a Boundary Approach</i> .....	151
4.3.3	<i>Cycles of Action and Reflection</i> .....	152
4.3.4	<i>Support Data Collection</i> .....	158
4.4	ENSURING QUALITY IN THE COLLECTION AND ANALYSIS OF .....	
	ACTION RESEARCH DATA .....	175
4.5	LIMITATIONS OF THE METHODOLOGY AND METHODS ADOPTED .....	177
4.6	CONCLUSION .....	181
5	<b>BUILDING THEORY FROM FIELDWORK: THE FINANCIAL SERVICES STUDY</b> .....	183
5.1	INTRODUCTION .....	183
5.2	THE CASE STUDY AND ITS CONTEXT .....	184
5.2.1	<i>The Organisational Cultures</i> .....	185
5.2.2	<i>The Branch Network</i> .....	186
5.2.3	<i>The Outcome of the Merger</i> .....	186
5.3	AIMS OF THE BANK STUDY .....	187
5.4	TYPES OF BOUNDARIES .....	187
5.5	PHYSICAL BOUNDARIES .....	188
5.5.1	<i>Job Description</i> .....	188
5.5.2	<i>Product Set</i> .....	191
5.5.3	<i>Location</i> .....	194
5.5.4	<i>Colleagues</i> .....	197
5.5.5	<i>Owners</i> .....	199
5.5.6	<i>IT System</i> .....	202
5.5.7	<i>The Branch Manager</i> .....	203
5.6	BEHAVIOURAL BOUNDARIES .....	206
5.6.1	<i>Personal Investment</i> .....	206
5.6.2	<i>Work Processes</i> .....	209
5.6.3	<i>Team Behaviour</i> .....	212
5.6.4	<i>Customer Service</i> .....	214
5.7	COGNITIVE BOUNDARIES .....	218
5.7.1	<i>Work Beliefs</i> .....	219
5.7.2	<i>Belonging</i> .....	223
5.8	CONCLUSION .....	226
6	<b>DISCUSSION ON THE FINANCIAL SERVICES STUDY</b> .....	228
6.1	INTRODUCTION .....	228



6.2	DEVELOPING THEORY ON BOUNDARIES IN M&As .....	228
6.3	BOUNDARIES AS CREATORS OF TENSIONS .....	229
6.3.1	<i>Managing Physical Boundaries and Surroundings Tension</i> .....	230
6.3.2	<i>Managing Behavioural Boundaries and Interaction Tension</i> .....	233
6.3.3	<i>Managing Cognitive Boundaries and Affective Tension</i> .....	237
6.4	A FRAMEWORK FOR BOUNDARY MANAGEMENT .....	240
6.5	APPLICATION OF THE FRAMEWORK .....	243
6.6	CONCLUSION .....	244
<b>7</b>	<b>BUILDING THEORY FROM PRACTICE: THE HOSPITAL STUDY .....</b>	<b>246</b>
7.1	INTRODUCTION .....	246
7.2	THE CONTEXT.....	251
7.3	CYCLE 1.....	253
7.3.1	<i>Diagnosing the Problem</i> .....	253
7.3.2	<i>The Action Phase: Building Belief</i> .....	260
7.3.3	<i>Outcome and Reflections</i> .....	267
7.3.4	<i>Working with Co-researchers in Cycle 1</i> .....	270
7.4	CYCLE 2.....	274
7.4.1	<i>Diagnosing the Problem: Rethinking and Consolidating</i> .....	274
7.4.2	<i>The Action Phase: Building Capacity</i> .....	276
7.4.3	<i>Outcomes and Reflections</i> .....	280
7.4.4	<i>Working with Co-researchers in Cycle 2</i> .....	282
7.5	CYCLE 3.....	284
7.5.1	<i>Diagnosing the Problem: the Drive to ‘Merger Day’</i> .....	284
7.5.2	<i>The Action Phase</i> .....	285
7.5.3	<i>Outcomes and Reflections</i> .....	296
7.5.4	<i>Working with Co-researchers in Cycle 3</i> .....	298
7.6	CYCLE 4.....	300
7.6.1	<i>Diagnosing the Problem: From Amalgamation to Normal Operations</i> .....	300
7.6.2	<i>The Action Phase: Normalizing Operations</i> .....	301
7.6.3	<i>Final Outcomes and Reflections</i> .....	302
7.6.4	<i>The Views on the Ground</i> .....	305
7.6.5	<i>Working with Co-researchers in Cycle 4</i> .....	308
7.7	CHALLENGES IN THE ROLE OF ACTION RESEARCHER .....	308
7.8	CONCLUSION .....	313
<b>8</b>	<b>THE ANALYSIS OF BOUNDARIES IN THE HOSPITAL STUDY .....</b>	<b>315</b>
8.1	INTRODUCTION .....	315
8.2	THE PROFILE OF BOUNDARIES IN THE STUDY .....	316
8.2.1	<i>Physical Boundaries</i> .....	316
8.2.2	<i>Behavioural Boundaries</i> .....	340
8.2.3	<i>Cognitive Boundaries</i> .....	355
8.2.4	<i>Conclusions on Application of Boundary Framework to the Hospital Study</i> .....	370
8.3	COMPARING BOUNDARIES ACROSS THE FINANCIAL SERVICES AND .....	
	HOSPITAL STUDIES .....	370
8.4	CONCLUSIONS.....	373
<b>9</b>	<b>DISCUSSION ON THE HOSPITAL STUDY .....</b>	<b>374</b>
9.1	INTRODUCTION .....	374
9.2	DRAWING BOUNDARIES.....	374
9.3	THEORIZING BOUNDARY SALIENCE.....	381
9.3.1	<i>Creating Group Cohesion</i> .....	385
9.3.2	<i>Validation by the Powerful</i> .....	389
9.3.3	<i>Creating a Sustaining Discourse</i> .....	392
9.3.4	<i>External Validation</i> .....	395
9.3.5	<i>‘Voice’</i> .....	398
9.4	REDUCING BOUNDARY SALIENCE.....	399
9.4.1	<i>Resolving</i> .....	400
9.4.2	<i>Pre-resolving</i> .....	404
9.4.3	<i>Isolating</i> .....	407

9.4.4	<i>Repopulating</i> .....	410
9.5	CONCLUSION .....	412
<b>10</b>	<b>DISCUSSION: BRINGING THE THREE PILLARS TOGETHER.....</b>	<b>415</b>
10.1	INTRODUCTION .....	415
10.2	ACHIEVING SUCCESSFUL OUTCOMES .....	416
10.3	BOUNDARY MANAGEMENT IN M&A INTEGRATION.....	418
10.3.1	<i>Theoretical Insight 1: Boundary salience occurs through a dynamic political process</i> .....	418
10.3.2	<i>Theoretical Insight 2: Strategies exist to legitimise and de-legitimise boundary salience in an M&amp;A integration</i> .....	422
10.3.3	<i>Theoretical Insight 3: A theory of boundaries can classify boundaries as physical, behavioural and cognitive</i> .....	427
10.3.4	<i>Theoretical Insight 4: At least three management intervention types can be related to impacts on boundaries</i> .....	430
10.3.5	<i>Theoretical Insight 5: The level of integration achieved will depend on the interplay between the management interventions and the strength of the strategies driving integration or differentiation</i> .....	433
10.4	PRACTICAL APPLICATION OF THE THEORY .....	438
10.5	CONCLUSION .....	442
<b>11</b>	<b>CONCLUSIONS.....</b>	<b>444</b>
11.1	INTRODUCTION .....	444
11.2	THE CONTRIBUTION OF THE WORK.....	445
11.2.1	<i>Generation of New Knowledge</i> .....	445
11.2.2	<i>Theory Development Process Adopted</i> .....	448
11.2.3	<i>Unique and Exemplar Study</i> .....	449
11.2.4	<i>Practical and Meaningful Impacts</i> .....	450
11.2.5	<i>Reflection on the Action Research Process</i> .....	452
11.2.6	<i>Personal Reflection and Development</i> .....	456
11.3	IMPLICATIONS OF THE RESEARCH .....	461
11.3.1	<i>Impacts for Theory and Practice</i> .....	461
11.3.2	<i>Future Research</i> .....	463
11.4	LIMITATIONS OF THE STUDY .....	465
11.5	EVALUATING THE THESIS .....	467
11.6	CONCLUDING COMMENTS.....	469
<b>12</b>	<b>BIBLIOGRAPHY.....</b>	<b>471</b>
<b>13</b>	<b>APPENDICES.....</b>	<b>490</b>

## List of Tables and Figures

List of Tables		Page
Table 1.1	The research objectives and their pathway	17
Table 2.1	Acquisition Integration Approaches	44
Table 2.2	Acquired Firms mode of Acculturation	59
Table 2.3	Acquiring Firms mode of Acculturation	60
Table 2.4	A framework for boundary management; linking boundaries and management interventions	77
Table 3.1	Comparison of <i>ontological</i> and <i>epistemological</i> positions	84
Table 3.2	The Action Research Process	101
Table 3.3	Anderson and Herr's Goals of Action Research and Validity Criteria	126
Table 4.1	The rationale behind selection of branches for study	141
Table 4.2	Coding Aid for Boundary Identification	141
Table 4.3	Ensuring research quality (based on Herr and Anderson, 2005)	176
Table 5.1	Physical boundaries in the financial study	188
Table 5.2	Behavioural boundaries in the financial study	206
Table 5.3	Cognitive boundaries in the financial study	219
Table 5.4	Boundary types for each boundary category	226
Table 6.1	Types of and tensions created by physical boundaries	231
Table 6.2	Types of and tensions created by behavioural boundaries	234
Table 6.3	Types of and tensions created by cognitive boundaries	238
Table 6.4	Examples of impacts of actions within boundary categories	241
Table 6.5	A Framework for boundary management linking tensions, boundaries and management interventions	243
Table 7.1	Cycles of Actions and Reflections in the hospital study	249
Table 7.2	Actions taken to create integration	260
Table 7.3	Mean and standard deviation scores for perceptions of awareness	268
Table 7.4	Mean and standard deviation scores for identification scales	269
Table 7.5	Mean and standard deviation scores for culture	270
Table 7.6	Scores on integration measures June 2007	304
Table 7.7	Identity scores June 2007	304
Table 7.8	Identity scores (collapsed scale) June 2007	304
Table 8.1	Key values identified in focus groups	357
Table 8.2	Mean scores on identification pre-merger	365
Table 8.3	Mean scores on identification post-merger	365
Table 8.4	Mean scores on identification for Cashel pre- and post-merger	366
Table 8.5	Comparison of physical boundaries in the financial and hospital studies	371
Table 8.6	Comparison of behavioural boundaries in the financial and hospital studies	372
Table 8.7	Comparison of cognitive boundaries in the financial and hospital studies	372
Table 9.1	Dimensions of Strategies for Supporting Separation	384
Table 9.2	Dimensions of Strategies for Supporting Integration	401
Table 10.1	Contribution of research phases to the development of theory	417
Table 10.2	Strategies used to legitimise and de-legitimise boundary salience	422
Table 10.3	Types of boundaries evidenced in each boundary category	428
Table 10.4	A framework for managing boundaries in an M&A	431
Table 10.5	Sources of boundary salience	437
Table 11.1	Quality criteria achieved in action research study	469

## List of Figures

Figure 3.1	Spiral of Action Research Cycles	103
Figure 3.2	The general method of theory building research in applied disciplines	121
Figure 10.1	Link between strategies, interventions and boundaries	434

## List of Abbreviations

Approx.	Approximately
HR	Human Resource
HSE	Health Services Executive
I/O	Insider/Outsider
INO	Irish Nurses Organisation
IR	Industrial Relations
M&A	Merger and acquisition
OD	Organisation Development
Pa	per annum
PCCC	Primary, Community and Continuing Care (a division of the HSE)
PLC	Public Limited Company
SIT	Social Identity Theory
STGH	South Tipperary General Hospital
WIT	Waterford Institute of Technology



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Finally, I wish to acknowledge the contribution of those that are closest to me. My parents, who inspired in me a life-long passion for education and growth and to whom I owe my success in life and of course my wife, Carol, whose love and inspiration makes the impossible achievable.



## Declaration

I confirm that this thesis is my own work (except where stated otherwise).

The thesis is submitted to the University of Warwick and I confirm that it has not previously been submitted for a degree at any other university.



---

Derek O'Byrne  
November 2008

## **ABSTRACT**

This thesis explores how boundaries can be changed during a merger. Change literature has generally assumed boundaries are an unproblematic aspect of organisation life; readily definable and easily changed. Evidence from the emerging field of boundary theory suggest otherwise with boundaries seen as socially constructed, complex and ever-shifting.

The thesis adopts an action-orientated methodology, drawing from three sources of theory building; existing theory, fieldwork and from practice. Defining boundaries as any difference between groups, the thesis categorises boundaries as physical, behavioural and cognitive and uncovers specific tensions that are unique to each boundary category and which require specific management interventions to resolve. Developing these insights, the action research study, a five-year process of merging two hospitals, explored how boundaries changed in practice, showing how boundary salience was influenced by two sets of interrelated strategies. One set drove integration and the other set drove separation.

The thesis concludes with five theoretical insights into boundary change. Principal among these is the insight that boundary change can only come about when the boundary tensions are reduced and when the strategies supporting integration are dominant.

The thesis contributes to the theoretical understanding of boundaries and M&A integration but also to the practising manager by providing a framework for the analysis of boundaries and the determination of actions that reduce tensions and create the appropriate environment for effective boundary change.

# **1 Introduction to Thesis**

## **1.1 Introduction**

Merger and Acquisition (M&A) integration is the management task of bringing together two distinctive organisations into a single unified entity. It has been suggested that one out of every three employees will experience a merger during their working life (Feldman and Spratt 1999) and that they will experience stress and uncertainty (Marks and Mirvis, 1998) as well as significant cultural (Cartwright and Cooper, 1997), organisational justice (Hubbard 2001) identity (Terry, 2001) and emotional (Kusstatscher and Cooper, 2005) challenges. There has been little discussion, until recently (e.g. Angwin 2007b; Stahl and Mendenhall, 2005), about our theoretical understanding of merger integration. This thesis will add to the emerging theoretical perspectives by considering the integration task from the perspective of boundaries. A boundary approach is appropriate because boundary conflicts are commonplace during merger integration; them-and-us situations often occur where differences in practices, beliefs or group membership hinder communication or cooperation and provide the basis of inter-group conflict. In addition boundaries also demarcate organisations from each other and must be disturbed or changed if two organisations come together as a new entity (Haspeslagh and Jemison, 1991). Boundaries are therefore at the centre of M&A integration. Little is known about how boundaries change, become salient or remain dormant within a merger. Boundary theory is a relatively new emerging field of study. Many different disciplines have usefully studied boundaries to explore issues of identity, belonging and inter-group conflicts but until recently (e.g. Paulsen and Hernes,

2003) there has been no attempt to develop a cohesive ‘theory of boundaries’.

The main objective of this thesis is to develop theoretical insights on how managers can change boundaries during a merger as a means of improving outcomes.

This chapter will set out the landscape of the thesis explaining the importance of the work and how the theoretical insights will be developed. The chapter will explain the importance of this research identifying the contributions that it intends to make to the fields of boundary theory and M&A integration.

## **1.2 Merger Integration and Boundaries**

Boundaries are everywhere. Our lives are shaped by reference to physical and notional constructs that define what we can or cannot do, to what groups we belong or don’t belong, what is work or play, home or office, family or stranger and so on. The distinguishing factor for these constructs is a boundary that allows individuals or groups locate themselves *vis-a-vis* others. In organisational terms boundaries define the organisation (Scott, 1998) and its identity (Haslam, 2001) codifying what is inside or outside the organisation or who is or is not a member of that organisation. It has been recognised that some organisational combinations whether merger, acquisition or other arrangement, involve changes to existing boundaries (Haspeslagh and Jemison, 1991). In such cases the existing organisational boundaries must be displaced (Haspeslagh and Jemison, 1991) and new boundaries must be created as people, technologies and cultures come together in the combined organisation. This thesis argues that boundaries are a much under explored component of merger integration. Boundaries and

integration are related insofar as integration is about building unity and boundaries are about separation. However to date no evidence has been collected on what actually happens to boundaries during a merger. M&As are a particularly fitting and fertile context for the exploration of boundaries and the application of a boundary perspective. When a high level of integration is required post-merger then the managerial task represents a distinctive boundary challenge. Two (or more) previously bounded groups must join together and create a new group combining their structures, people, processes and technology to transcend their existing boundaries and formulate new boundaries. The importance of organisation integration in delivering on merger and acquisition outcomes has been well documented (Pritchett, 1997; Datta, 1991; Ravenscraft and Scherer, 1989; Shrivastava, 1986) as have the ongoing problems that are often encountered. Shrivastava (1986), for instance, suggests that one-third of all acquisition failures are a result of integration problems. The myriad of dysfunctional outcomes identified as arising from poor integration processes include increased levels of stress (Marks and Mirvis, 1997a; 1997b), low productivity levels (Hambrick and Cannella, 1993), staff turnover (Hayes and Hoag 1974), senior management turnover (Angwin, 2000), loss of identity (van Kippenberg and van Leeuwen 2001) and poor overall performance (Selden and Colvin, 2003; Hall and Norburn, 1987). This thesis takes as its starting point that the decisions on structural realignment have been made. The focus is therefore on the behavioural responses at individual and group levels that result in new structures being accepted (or rejected) rather than on the design of those structures.



### 1.3 Objectives of the Thesis

This thesis addresses a new theoretical area building from the intersection of two distinct fields of study, an emerging field of boundaries and an established field of M&A<sup>1</sup> integration. The thesis explores how a boundary approach can be used to design management interventions to improve merger outcomes. Boundaries have received little attention in the M&A literature, often relegated to a minor component of organisational design that can be readily determined by M&A planners. Hence boundaries are described in terms of the decision to change them or maintain them (Haspeslagh and Jemison, 1991). Such views are, it will be argued, oversimplifications of a complex social phenomenon that can provide a source of potential conflict. In this regard researching boundaries offers an opportunity to explore M&A integration from a new perspective and address a gap in the literature. This thesis will develop new theory on boundaries, how they operate within merger integrations and more importantly how they might be managed to improve merger outcomes.

Increasingly attention has been paid to the role of boundaries in affecting organisational processes (e.g. Paulson and Hernes, 2003). Diverse fields of literature have addressed boundaries as enabling groups to separate, join and transcend social and physical structures. These are the very processes at the heart of M&A integration, yet no direct attention has been paid by M&A scholars to the impacts boundaries have on integration success. When boundaries are discussed they are usually defined as unproblematic, capable of being drawn and redrawn by managers at will. Evidence from other fields however suggests that

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<sup>1</sup> For the purpose of this thesis the terms merger and acquisition will be used interchangeably.

boundaries have more complex interactions and outcomes. This work is a systematic attempt to codify boundaries in an M&A and to build theoretical insights that will assist managers to manage boundaries to improve merger outcomes.

The conceptual link between boundaries and M&A integration emerged as much from personal practice as from literature reviews. Resistance to change is often expressed in terms of definable boundaries, whether they are historical practice, limitations on current systems or philosophical objections. I have on many occasions had change initiatives fail for such reasons. I have struggled to understand how these barriers emerge, particularly, when they are set against rationally expressed logic (at least to me). My interest in boundary management is therefore not just theoretical but also personal and practical.

The philosophical tradition adopted in the study emphasizes the important link between theory and practice and the need to ground research in practical outputs and outcomes that impact on and improve the lives of people. This tradition is based on the Organisation Development movement and the work of Lewin (1946), Dewey, (1991) Greenwood and Levin (1998) and Coghlan and McAuliffe (2003). Drawing on the traditions of action research the work will use a multi-method approach that draws together multiple strands of data and experience to impact on real-life outcomes. A clearly expressed measure of success for the theory building is therefore its capacity to impact on merger outcomes in practice. The overall question posed by this thesis is:

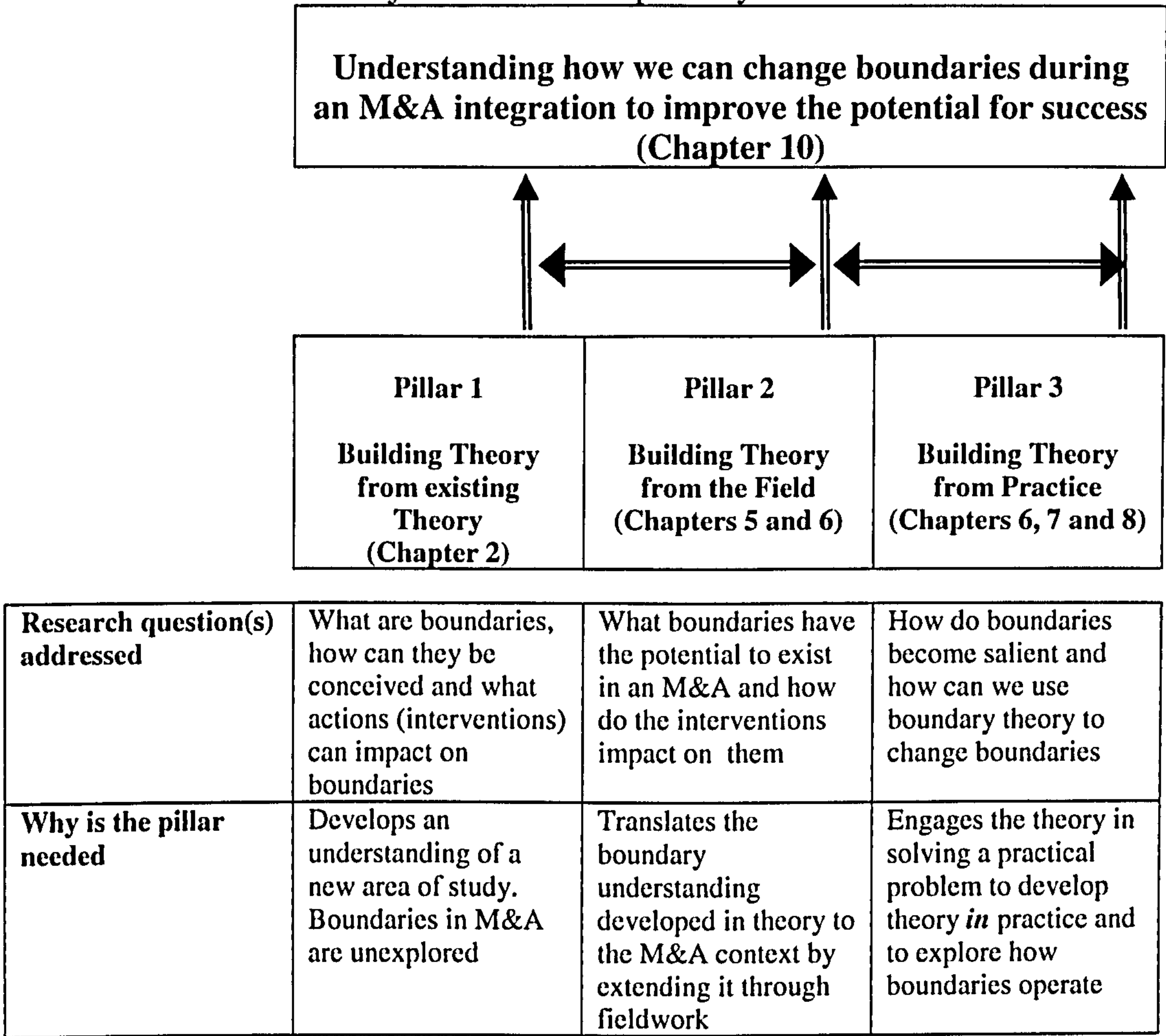
## **How can we change boundaries during an M&A integration to improve the potential for success post-merger?**

Answering this question is not a simple task given the dearth of existing knowledge on boundaries in M&As. However, a number of diverse fields of study have addressed boundaries from which a boundary construct can be developed. There is no published work on what types of boundaries exist in an M&A nor on how they in turn become salient or remain dormant during an integration. To address the question of how to change boundaries it is therefore important to develop four ancillary questions:

1. How can we conceive boundaries and how can management act to impact on them?
2. What boundaries have the potential to exist during an M&A integration?
3. How do boundaries become salient during an M&A integration?
4. How can management support changes that create new boundary configurations in line with the objectives of the M&A?

These questions represent a cumulative approach to theory building starting with the need to understand the concept of boundary leading to an understanding of the types of boundaries that may exist and their potential to impact on merger integration (the financial services study) and finally to understand how management interventions can reduce the potential impact of boundaries and foster new boundary configurations (the hospital study). This iterative process represents the design of the thesis (see table 1.1).

Table 1.1: The research objectives and their pathway



1.4 Importance of this Work

It is well established that success rates in M&As are poor, whatever measure of success is adopted (Angwin, 2007a; Cartwright and Cooper, 1997; Feldman and Spratt, 1999; Hall and Norburn 1987; Kitching, 1974), and on average at least 50% of mergers are likely to incur sub-optimal outcomes. Furthermore over the past decade research in M&As have moved from pre-acquisition planning to post-acquisition integration as explanations of the poor performance statistics. By developing our understanding of the post-merger phase it is expected that more light can be shed on the causes of failure and on the actions that can improve outcomes. Post-merger integration however is a complex change activity with



impacts across human, technical and cultural systems. It is anticipated that adopting a boundary perspective will help develop understanding and explanation and will serve to extend the current debates on post-merger integration, identity and outcomes.

A second reason why the research is important is that it presents a new conceptualisation of M&A integration through an understanding of boundary management. Boundaries are an underdeveloped and under-explored aspect of organisational life, usually defined as static, determined by design and readily changed by system and organisational theorists (Checkland, 1999; French and Bell, 1995; Scott, 1998). Heracleous (2004) has suggested that there has been little serious attention to boundaries within the management literature and that boundaries are most often conceived as ‘unproblematic.’ Theories of boundary have, however, been fruitfully adopted across many other disciplines to explain phenomena at the heart of M&A integration notably resistance, control and growth. By addressing the boundary conditions within mergers this thesis opens up new and exciting avenues of organisational exploration and provides for new organisational paradigms to emerge.

Finally, I argue that the importance of research lies in the impact that it has on the understanding and practice of individuals and groups. Following in the action research tradition (Greenwood and Levin, 1998; Coghlan and Brannick, 2005 and Dewey, 1991) I take the position that the defining character of good research is that it systematically tests our theories (both in use and espoused) and leads us to new and improved practices. This is the action and organisation development



orientation that is adopted as the underlying theoretical frame of the research. By conducting research in practice rather than on practice it is possible to integrate theoretical and practice insights and provide stronger evidence to support theory development as well as ensuring the relevance of the outputs. Indeed as well as producing outputs (the tangible deliverables such as theoretical statements) action research methodologies also seek outcomes, which are sustainable changes in individual or group behaviours and cognitions that relate to personal practice as well as knowledge. In this way research, action, knowledge and practice become closely intertwined.

## **1.5 Contribution of the Research**

To assess the quality of the research conducted it is important to establish the contribution that the work should make to the development of new knowledge and to express clearly how that contribution can be measured. The objective of the thesis is to establish how boundaries can be changed in an M&A. In this respect the primary contribution of the thesis should be to develop theoretical insights into boundary management. The action orientation of the thesis also establishes the need for that theory to be grounded in practice and to be easily transferable into a practice-orientated setting. It is the overall aim of the thesis that the output will contribute to an understanding of how a boundary management approach can improve the potential for successful merger integration. This represents a major contribution to knowledge as it will

1. generate new theoretical insights into boundaries in an M&A;
2. generate new theoretical insights into how boundaries become salient, change and respond to given interventions from management;

3. provide guidance to management to improve practice and to enhance potential integration success.

In addition to the contribution to new knowledge from the theory development, the method by which the research is to be conducted integrates the research process in a unique manner. It is designed to build theory by triangulating three strands of knowledge generation:

1. knowledge generated from existing theory which informs the development of theoretical insights;
2. knowledge generated from field work (interviews and qualitative data collection) that develops knowledge from the practice of others and
3. knowledge generated from practice that co-develops knowledge with others in their practice.

In this way the thesis builds from deductive, inductive and action approaches extending on the more traditional method that will emphasise a single strand approach. New insights can be developed through this multiple method and by comparing and contrasting data from each method the strengths of each method can be harnessed. The research moves from theory to the field to practice but all three sources triangulate to inform and reinforce theoretical insights from each other (see table 1.1 for the design and figure 10.1 for the outputs). In this way a multiple perspective is generated that strengthens the outputs. In addition to the multiple theory development approaches adopted the thesis also contributes in terms of the longitudinal focus of the research. While the initial study, the financial services, mixes historical and longitudinal data, the second study, the

hospital, represents a unique case of longitudinal study. Action research, by its nature, is conducted in practice and must be longitudinal (taking place over the time of the events being acted upon). However in the hospital study the delays and problems encountered resulted in a longer than expected timeframe of study. The merger of the hospital was characterised by disputes, delays, industrial action and significant bouts of conflict. The action research process commenced in November 2003 and was finalised in April 2008. The data was collected over a three-and-a-half-year period of integration planning within a turbulent environment and in this respect represents both a unique insight into the context of the hospital and also an extreme case of study. The methods adopted therefore also contribute to new knowledge insofar as:

1. the work represents a triangulated approach to theory building and development integrating multiple techniques for theory generation;
2. the work contributes to a limited body of existing longitudinal research on M&As;
3. the hospital study represents a unique and extreme case of a problematic integration.

The third major contribution that the research makes stems from the action orientation and the underlying philosophical traditions that inform the method. Action research (AR) should produce both outputs and outcomes. AR involves sequential cycles of action, evaluation and reflection leading to questioning both the theoretical assumptions underpinning action and the process by which action and learning take place within the social context. At the meta-level (the cumulative learning from all the cycles of action) AR generates knowledge about

the phenomenon being investigated (M&A integration in this thesis) and about the process of learning itself. In this respect it has both change and individual or group development as key metrics in assessing the value of research. AR values participation as a component of both knowledge creation and of the generation of change outcomes in practice. Delivering on expected outcomes is a critical success component of any action research process. Furthermore AR emphasises reflection and sustainable learning as necessary outcomes of an AR process. This is a contribution to knowledge both for the self and for those that participate in the research. Reflection should indicate how the practice of the individual (researchers and participant co-researchers) has changed as a result of the interactions and knowledge generated and how the relationships between people, the understanding of variant perspectives and the sharing of experiences have changed practice at the system level. Argyris (1993,1999) distinguished between single- and double-loop-learning. Single-loop learning impacts on the task with no subsequent impacts on ongoing practice. In contrast double-loop learning creates sustainable changes in cognition about the task and results in deeper learning that will change subsequent behaviours. For action research to be effective, double-loop learning must take place. A third suite of contributions will therefore be made by this work which reflects on the practice of all the participants in the AR research process. These include:

1. delivering on the integration task and achieving a functioning post-merger hospital in line with the unfolding objectives of the action research cycles;
2. building sustainable double-loop learning for participants in the research process;



3. creating sustainable learning that will benefit the practice at the hospital level.

These lists of contributions represent an ambitious agenda for the thesis but many of them are intertwined with the method and philosophy of the research design.

In that respect the quality of the research and the measures of success are explicitly linked to the delivery of these contributions.

## **1.6 The Structure of the Thesis**

The justification of the research and the overview of the objectives and desired outputs of the research have been discussed in this chapter. Leading on from that Chapter 2 will address the first pillar of the theoretical development process by exploring the role of boundaries in M&As and by developing a theoretical framework that will guide the study of boundaries in both the financial services and hospital studies.

Chapters 3 and 4 will deal with methodology and method decisions respectively and will present the ontological, epistemological and methodological assumptions that underpin the action orientation of the research question. These chapters will also address the need to ensure quality in the processes of action research and theory building and present a framework through which the outcomes and outputs of the research can be assessed.

Chapters 5 and 6 deal with the financial services study. Two chapters are presented, the second of which is dedicated to the discussion of boundaries in the study. The decision to include this chapter (and chapter 9) as separate chapters



was based on the need to show the sequential nature of the theory building and to show the links between the findings of the study and the action research interventions in the hospital. Chapter 6 unbundles the boundary categories and presents a list of boundary types that exist in each category. The chapter also proposes a set of theoretical understandings about interventions and their impacts on boundaries.

Chapters 7 through 9 deal with the hospital study. The first of these chapters discusses the action research conducted in the hospital and narrates the study of the merger. Chapter 8 deals with the boundaries that existed in the study and compares and contrasts those with the financial study supporting the findings of that study. The final chapter discusses the study to develop further theory on boundaries, notably the understanding of how boundary salience occurs.

Chapter 10 answers the main question of the thesis by discussing the work in its totality and drawing together the three strands of theory development. Five theoretical insights are proposed that explain how boundary salience occurs, how interventions impact M&A boundary change and how to change boundaries in practice.

Chapter 11 draws the thesis to an end by evaluating the thesis against the criteria established in this chapter and in the methodology and method chapters. It draws out the contribution of the work and its implications for theory, practice and for future research. The chapter concludes that the thesis delivers on the objectives it sets and provides new insights into the management of M&As.

## **2 Developing Theory from Theory: Integrating M&A and Boundary Literature**

### **2.1 Introduction**

This thesis argues that exploring M&A integration from the perspective of boundaries can be an effective way of improving M&A outcomes. M&A literature recognises that boundary change is necessary in certain types of combination, notably when high levels of interaction, coordination and resource sharing between combining organisations is a necessary condition of delivering on strategic objectives (Haspeslagh and Jemison, 1991). In these circumstances the merging organisations must create a new unified organisation and shed the boundaries that previously defined each organisation as a separate entity.

Integration and boundaries are the antithesis of each other: integration creates unity, boundaries separate and divide. If merging organisation need to achieve high levels of integration then paying attention to boundaries and reducing or removing the salience of potential boundaries should increase the level of integration. However, the management of boundaries in M&A integration has remained largely unexplored. M&A scholars have tended to view boundaries as stable and static, readily drawn and redrawn, at will, by organisational designers. Haspeslagh and Jemison (1991) for instance relate acquisition objectives to the extent to which boundaries are ‘disturbed’ and provide advice on how the boundaries of firms can be preserved or permeated by Integration Managers. Others such as Marks and Mirvis (1991) and Lars (1999) have drawn from this conceptualisation of boundaries as physically ‘protectable’ while Hubbard (2001) suggests that ‘boundaries must be redefined in clear and unequivocal language as

a way of establishing post-merger expectations (p.164). Puranam, Singh and Zollo (2006) relate levels of innovation in technological mergers to boundary conditions and note that by grouping organizational units within common administrative boundaries through structural integration, an acquirer can simplify coordination and facilitate mutual adaptation (p.265). Similarly acquisition scholars have adopted organisational perspectives as economic or resource views of firm behaviour that support stable views of boundaries (i.e. Kapoor and Lim, 2007; Capron; 1999). All of these examples assume boundaries as stable and static and do little to explore the nature of boundaries or how boundary changes can be brought about. In contrast studies on boundaries suggest that boundaries act in dynamic ways to impact on and influence change. By specifically addressing boundaries in M&As this chapter will integrate two diverse fields to develop a new perspective on how M&A integration can be informed through the understanding of boundaries. This will set a framework for understanding boundaries and analysing and unbundling boundaries in the field study (chapter 5) and action research study (chapter 7).

To achieve these aims the chapter will start by exploring the nature of boundaries and developing a construct of boundaries that explains how they impact on organisation life. The chapter will then review the M&A literature in the light of a boundary framework examining the theoretical background to integration and the management actions used to aid integration. Specifically, the chapter will

1. Explore the nature of boundaries;
2. Explore the context and task of M&A integration locating this work in the field of M&A integration;

3. Explore the process of integration and the management challenges that arise in the process;
4. Codify the managerial actions that can be taken during an integration process;
5. Develop a framework that integrates boundaries and M&A literature for use in the financial and hospital merger studies.

The output from this chapter will be the first stage (of three) in the development of theory on boundary management in M&As. It will develop the theory by combining the existing theoretical insights within the M&A and boundary fields to develop a framework that can be used to explore boundaries in the research studies. Table 2.4 at the end of this chapter brings together the two literatures by combining the management interventions commonly adopted to prevent integration problems with a construct of boundary categories that might arise in a merger. The table provides a matrix for analysing how boundaries might be managed to improve merger outcomes.

## **2.2 The Nature of Boundaries**

Boundaries are gaining attention in management literature, evidenced by a special edition of *Human Relations*<sup>2</sup> specifically focused on conceptualising boundaries and contributing to the ‘*scholarship of boundaries*’ (Gabriel and Willman, 2004 p.8). Many fields of study have considered boundaries as a component in the explanation of behaviour. Disciplines, as diverse as geopolitical theories (Paasi, 1999), communication (Petronio et al 1998),

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<sup>2</sup> Human Relations volume 57 no. 1 (2004)



transaction cost economics (Williamson 1981; Barney, 1999), resource dependency (Pfeffer and Salancik, 1978), population ecology (Hannon and Freeman, 1977, 1980), identity (Tajfel and Turner 1986), psychology (Puddifoot, 1997), sociology (Lamont and Molnar, 2002), leadership (Gilmore, 1982) and strategy (Barney, 1999; Brooks, 1995; Jemison, 1984) have addressed boundaries. Little attention (with the noted exception of the special edition of *Human Relations* and the work of Paulsen and Hernes, 2003) has been paid to boundaries in the management literature despite boundaries being at the centre of change. For instance, Paulsen (2003) suggests that all change involves ‘constantly redefining and renegotiating group boundaries’ (p. 15) and Hernes (2004) suggests that they are central to all change efforts (p.10). A greater understanding of the existence, roles and operation of boundaries will therefore add insights into how merger change can be more effective.

### 2.2.1 *Conceptualising Boundaries*

Boundaries are an integral part of our everyday life and we encounter and sustain them repeatedly often without conscious recognition. Boundaries demarcate work from home, they separate family from friends, and they differentiate us from others by reference to our gender, age or social differences. They also differentiate across organisations, defining competitors, suppliers or customers both within national and international boundaries. Similarly, they differentiate within organisations, separating one function from another, one work-group from another and one level of hierarchy from another. Hernes (2004) suggests that boundaries are



- 'composite insofar as organisations operate within multiple sets of co-existing boundaries. These sets of composite boundaries vary from organisation to organisation, in strength as well as in substance.
- central, not peripheral to organisations. Change processes in organisations are about creating, moving or consolidating boundaries. Hence boundary properties reflect the very substance of the organisation.
- constantly subject to construction and reconstruction. Boundaries are not static givens, but are under constant change. This does not prevent some boundaries from being relatively stable, while others change more rapidly' (p.10).

Organisational theory has tended to consider boundaries as tangible and definable aspects of structure that are analytically drawn and stable. For instance, Thompson (1967) saw organisational boundaries as drawn and defined by planners as a means of closing off organisational systems to external variation. System analysis suggests that the designers of systems can define the system parameters to bound their complexity (Scott, 1995; Checkland 1999). In contrast boundaries are increasingly seen as amorphous and difficult to identify (Rafaeli and Vilnai-Yavetz, 2003) or reproduced through social interaction (Giddens, 1984). Social identity theory, for instances, shows how groups create social boundaries to differentiate one group from another in order to maintain status differentials (Tajfel and Turner, 1986). Kerosuo (2003) demonstrates the permeable nature of boundaries and that they emerge intertwined in everyday activities.

Yan and Louis (1999) presented one of the first systematic attempts to draw together and discuss a variety of perspectives on organisational boundaries. They conceptualized boundaries as

1. demarcations,
2. perimeters,
3. interfaces, and
4. frontiers for transactions.

Demarcations distinguish one social system from another and provide a means of understanding the conditions that separate the systems. For an organisation to exist it must be separated from others (Scott, 1998). Separation usually relates to a physically defined space whether territory, technology or time (Miller and Rice, 1967), that distinguishes the organisation from others, for example, different customer markets, different products, or different locations in the supply chain. Accordingly, focusing on boundaries as demarcation primarily addresses the link between the organisation and its environment (Scott 1998) and defines the parameters of organisations *vis-a-vis* that environment. However, demarcations can also arise in behavioural factors such as work-life balance (Ashford et al, 2000) or relationships (Bacharach et al, 2000) and through cognitive factors such as culture (Hawley, 1995; Shamir and Melnik 2003).

Boundaries also establish perimeters. Thompson (1967) considered boundaries as perimeters in his development of systems theory by considering them as a mechanism to close off a system from undue external disturbance. He argued that

system designers establish boundaries to buffer the organisation from interference. Boundaries protect by closing off the organisation so that it can be free from disturbances originating from outside. Geopolitical theories (Paasi, 1999) draw heavily on notions of protection and associated notions of control, independence and sovereignty. Similarly, resource dependency describes how boundary and boundary spanning activities can reduce external organisation interference by regulating information and material flows (Leifer and Delbecq, 1978; Jemison, 1984). Perimeters also entail a cognitive or symbolic dimension. For instance, Wels (2003) demonstrates the interplay between physical and symbolic dimensions of perimeters from an anthropological standpoint in his study of a fence around a conservancy in Zimbabwe and how it acted to create conflict. While Paasi (1999) has demonstrated how Finnish-Russian boundary disputes revolved around the identity of peoples and how the forced removal and replanting of people in border domains served to reduce reintegration claims.

Boundaries, as interfaces, create flows of communication and transactions between systems as they interact with one another. This approach to studying boundaries focuses on exchanges of inputs/outputs and communication flows at the boundary interface. Transaction cost economics is the classic case of boundaries as interfaces, proposing that boundary locations should be determined by the cost ratio of including or excluding activities within the focal organisation (Williamson 1981). Interfaces also occur however at a social level. By their very nature boundaries exist simultaneously at the end of and the beginning of different domains. Hence boundary studies must consider the importance of boundary crossing as people, technology and ideas intersect at these boundary

points. Boundary crossing is particularly important in work-home balance research (Nippert-Eng, 2003, 1996a, 1996b) which charts how individuals transfer from a work environment to a home environment through enacting boundary roles. An interesting example of how a boundary can create interfaces is evident in the work of Rafaeli and Vilnai-Yavetz (2003) who describe how changing the colour of a fleet of buses in Israel resulted in significant interaction between a wide variety of stakeholders and the company to both positive and negative effect. They conclude that there is a need to consider boundaries from both inside-out and from outside-in and that while *there may be a managerial desire and attempt to define certain boundaries,... the actual definition is a product of some dynamic interplay between the organization, its artifacts, its constituents, and the issues that they may raise* (Rafaeli and Vilnai-Yavetz 2003, p.207).

Finally, the frontier perspective is intended to extend the interface perspective by relating boundaries to the transactional nature of the environment, considering boundaries as the 'marketplace' in which transactional activities takes place. Drawing on the boundary spanning literature they argue that organisations actively manage through reaching out to the marketplace to ensure ongoing viability of the organisation in terms of resource acquisition, organisational legitimacy and as a market for outputs. The frontier metaphor has resonance with views of organisations as trying to extend the range of its boundaries to gain control over their environment. For instance, Pantelli (2003) suggests the boundary-less or virtual organisation should be viewed not as eliminating boundaries but rather extending them by including aspects of traditionally non-



work organisations (i.e. home) within their control. He argues that boundaries do not disappear but rather are enacted in different ways to legitimize roles within new forms of work. For instance how work tasks can be integrated with home-working extends the control of the organisation into home space. Similarly, Garsten (2003) shows how work practices for temporary agency staff transcend traditional boundaries but also result in the creation of new types of work boundaries pushing the frontiers of existing work boundaries.

Marshall (2003) provides an alternative (but reconcilable with Yan and Louis, 1999) range of perspectives on boundaries. He suggests boundaries can be viewed

1. through the metaphor of containment,
2. as a permeable membrane,
3. as socioculturally constructed.

The container metaphor combines the demarcation and perimeter concepts suggested by Yan and Louis (1999). A container distinguishes inside and outside, is objectively definable and stable. The metaphor stands for traditional notions of organisation that strive for internal consistency and stability. Marshall suggests that the container view promotes a unitary model of organisation where coordination and integration is assured because of the mechanistic nature of effective organisation.

The characterizing of boundaries as permeable membranes draws on the interface and frontier categories to emphasise the interaction between inside and outside of

the boundary. Boundary crossing is an inevitable process driven by the need for organisation survival. Drawing on Maturana and Varela (1987), Marshall argues that the environment is not something that is 'out there' but rather something that is 'defined by self-regulation and recursive generation of components in interaction' (p.60). Transfers across the boundary co-create the organisation and the environment by defining each in terms of the other. In this way the boundary between organisation and environment creates organisational identity by differentiation from the environment.

Marshall's third category considers boundaries as socioculturally constructed. Drawing on Luhmann (1995), Marshall argues that boundaries are actively produced and reproduced through an ongoing dynamic and contested process of negotiating inclusion and exclusion. In this way boundaries are not something to be 'put in place' but are actively constructed, maintained and reproduced within social interactions. Socially constructed boundaries contrast strongly with perimeter or demarcation constructs which consider boundaries as tangible and objective. Constructed boundaries are idiosyncratic, context-dependent and arbitrarily located. Attempts to objectively draw any line that distinguishes inside from outside is therefore fraught with problems. However, as Marshall points out it is important not to conflate the arbitrariness of boundaries with the existence of boundaries. Enacted or socially constructed boundaries have real impacts on social interaction. Drawing on Goodman (1984) he concludes that the way in which we divide up the world, according to sets of perceived similarities and differences has impacts on how we perceive, how we act and how others see us. Marshall also points to the dual nature of boundaries as creating belonging,

solidarity and security while simultaneously creating exclusion and alienation.

Defining what you are also defines what you are not.

### *2.2.2 Defining and Classifying Boundaries*

Leading from the above discussion the most common approach to considering organisational boundaries is to consider what is with-in or with-out the organisation and the way inside and outside are differentiated. In that respect boundaries can be defined in terms of difference. A boundary can be any facet of an organisation that can be used to differentiate one social group from another whether by design or through arbitrary sociocultural enactment.

Boundaries are socially constructed, residing in the minds of those who create them. They have physical and behavioural manifestations. For instance, Ashforth et al (2000) argue that groups evolve and differentiate along physical, cognitive and relational dimensions. They have shown how role transitions from work to home can often entail physical changes (i.e. location), behavioural routines (i.e. changing clothes, nurturing versus managing roles) and cognitive impacts (i.e. recreation time). Similarly, boundaries have been shown to be ways in which individuals (or organisations) can simplify and order their environment (Michaelson and Johnson, 1997; Zerubavel, 1991) by defining roles, responsibilities and expected behaviours that exist within that domain and how that differs from those outside that domain. Boundaries have also been considered as created or enacted (Ashford et al, 2000) or consisting of 'mental fences' (Zerubavel, 1991) and are, as Bacharach et al (2000) suggest 'limits of



self' and as Nippert-Eng (1996a, 1996b) have shown, 'idiosyncratically constructed.'

Three categories of boundaries appear regularly in the literature and these are physical, behavioural and cognitive categories. Ashford et al's (2000) description of boundaries emerging along physical, relational and cognitive dimensions has resonance with both the work of Hernes (2003, 2004) and Rafaeli and Vilnai-Yavetz (2003). Rafaeli and Vilnai-Yavetz (2003) use artefacts (the colour of a bus in their study) as a symbol of boundaries and argue that a symbol has instrumental, aesthetic and symbolic dimensions. Instrumental relates to the function and objective use of an artefact. Aesthetics are the sensory impacts which elicit a behaviour or emotive response, and symbolic effects are the wider meaning an artefact evokes in the mind of the observer. These closely relate to boundaries as physical, behavioural and cognitive. Hernes (2003) draws on Scott's (1995) three pillars of institutions, regulative, normative and cognitive structures and Lefebvre's (1991) distinction between physical, social and mental space to discuss boundaries as originating from physical, social and mental processes. Hernes (2004, p. 14) suggests that physical boundaries are made up of tangible entities either in the form of 'material positioning' (visible perimeter that differentiates space) or in terms of regulation (regulate flows of interaction and behaviour). While Hernes includes behavioural through regulation as a physical characteristic, there are differences between the tangibility of physical artefacts, such as walls, desks and people and the more abstract translation of norms into behaviour routines. Behaviour routines emerge as much from the construction of social and political interaction as they do from the regulatory



framework codified by an organisation (Pfeffer, 1991). The second boundary category described by Hearnés is social. Group social norms create identity and enable the creation of ‘otherness’ (Harvey 1990). He ties the concept to behaviour arguing that the link between identity and behaviour is assumed in many sociological works (Giddens, 1991; Castells, 1997 and Elias, 1994). Finally, he identifies mental boundaries which consist of the mental sphere within which we make sense of the world. Mental boundaries describe the particular mental routines that enable individuals and groups to communicate, to understand and to act. In effect they are the social construction process that facilitates sense-making (Weick, 1995) to emerge. These works clearly demonstrate that boundaries can be defined as difference and that differences occur in physical, behavioural and cognitive dimensions.

### *2.2.3 Boundaries as Ever-shifting: Boundary Salience*

Defining boundaries as difference does not imply that boundaries should be viewed as rigid or static. Some group differences, for example, gender or nationality may be permanent and unchangeable. Even though the difference is permanent it does not imply that it will differentiate all social situations. It may be relevant in some cases, for example a social discourse, but not in others such as a work context. For any given social context therefore there may be a number of possible dimensions on which groups can be divided but that is not to suggest that the division is one that the groups themselves enact as a difference in that social context. In this respect it is not the existence of boundaries that is important rather it is the group’s enactment of the boundary as salient in the given context. A critical question accordingly is how boundaries become salient

and how do changes in boundaries subsequently occur. Little in the literature fully explains how boundary changes occur in social contexts. There have been several strands of research that underpin how transition between boundary states occur, for instance the work of Nippert-Eng (2003 1996a, 1996b) on work-role transitions or Shamir and Melnik's (2003) work on cultural transitions. Perhaps the best example of how boundaries evolve comes from Hawley's (1995) explanation of the Amish entrepreneur who continually redefined her boundaries with her community. In this instance the entrepreneur continually 'pushed the limits' of acceptable behaviour until she was refused permission to continue. In this way the boundary was tested by being challenged. This challenge occurred from justifying and positioning the boundary extensions by aligning them with the interests of the community. Similarly, Gilmore (1982) has considered the leader as a creator of environments through the negotiation of boundaries and the regulation of transactions across those boundaries while Bacharach et al (2000) have discussed boundary setting as a managerial device used to manage relationships. Central to these works is the importance of inter-subjective assessments to understand both the existing boundaries and the logic in why those boundaries are changing.

Social identity theory has considered salience from the perspective of identities and inter-group assessments of differences that groups use to differentiate themselves from others to create a positive self-image. Hogg and Terry (2001) suggest that identity salience occurs when our 'cognitive system matches social categories to the social environment and brings into active use that category which renders the social context and one's place within it subjectively most

meaningful' (p.7). Salience is a function of two processes, accessibility and fit. Accessibility relates to the range and type of identity categories that are available within a given context and fit emerges from the matching of the available categories based on structural or normative perceptions. For example, gender may be an accessible category that might be perceived to be important based on the social interaction within a gender differentiated social situation. Social identity theory is considered more fully in section 2.6.2.3.

### **2.3 Toward a Construct of Boundaries**

Summarising the discussion on boundaries leads to a number of theoretical statements:

1. Boundaries are socially constructed as well as physical in nature;
2. Boundaries serve multiple functions, often contradictory such as simultaneously, separating and joining groups from one another;
3. Boundaries can be defined in terms of differences between groups;
4. Differences can emerge from physical space and artefacts, from actions and behaviour routines and from the 'mental fences' arising from cognition;
5. Boundary conflicts occur when differences between groups are defined as salient within a given context.

These five statements represent the assumptions from the existing literature and from which theoretical insights on boundaries can be developed. These statements allow a framework for analyzing boundaries to be proposed. Based on



the earlier discussion three categories will be used to explore their identification and analysis. As suggested in section 2.2.2 these will be

- a) physical (or spatial) boundaries,
- b) behavioural boundaries,
- c) cognitive boundaries.

### *2.3.1 Physical Boundaries*

Similar to Hernes (2004), physical boundaries are the tangible and visible divisions between an organisation and its environment or between units within an organisation. These tangible differences arise from clearly demarcated rights to ownership of physical aspects of the business. The most obvious of these is the core operating technology, tasks and products within the firm and the relevant resources underpinning them. It is most often these physical aspects of the business that generate the value creating potential within a merger. Physical boundaries might also include the buildings, products, procedures, or even the name of the company. A distinguishing feature of physical boundaries is that they are bounded by space. Accordingly it is physically clear when one is inside or outside of boundary, e.g. in the office or outside the office. Physical boundaries represent tangible 'things', people or artefacts that can be identified as belonging within that boundary.

### *2.3.2 Behavioural Boundaries*

Behavioural boundaries arise from differences in behavioural norms and practices. Membership of an organisational or social system imposes norms of behaviour defining not only the tasks to be completed but also the relationship



with others and the expectation of how one should act within those relationships. Different firms have very different behavioural expectations. Some emphasise supportive actions while others emphasise competition and debate. Many behavioural boundaries may however operate on a very subtle level such as dress code, approach to problem solving and managerial styles or cultural behavioural patterns. The distinguishing characteristic of the behavioural boundary is that it reflects the taken-for-granted actions that are normal for that firm.

### **2.3.3 *Cognitive Boundaries***

Drawing on the social and mental boundaries identified by Hernes (2004) cognitive boundaries result from the way organisations make sense of the world around them. They arise from beliefs and values and represent the potential for differences that arise from the underlying assumptions that individuals take for granted within their work. The world we live in is too complex to understand in its entirety so we must accordingly bound the information and stimuli we receive to facilitate making sense of it. Cognitive boundaries represent the identity that organisations develop and the sensemaking activities that define how groups produce and reproduce that identity.

## **2.4 The Context for M&A Integration**

The second part of this literature review is to explain M&A integration and how it relates to boundary management. M&A integration is concerned with bringing two organisations together and translating the strategic goals into an organisational framework that facilitates the achievement of those goals. Integration and boundaries are related topics in that integration involves taking two separately bounded units and combining them into one unit so that they

share a common boundary. Different types of mergers require different levels of integration and integration can be considered as a continuum of no integration (i.e. conglomerate holding) or complete integration between the two organisations (where one or both companies cease to exist post-merger). Haspeslagh and Jemison (1991) suggest a framework for identifying the extent of the integration required. They consider two dimensions to the decision, the level of strategic interdependence between the two firms and the level of organisational autonomy needed by the acquired company (table 2.1.)

#### *2.4.1 Strategic Interdependence*

Strategic interdependence is concerned with the degree to which the objectives of the merger require the combining organisations to be coordinated and act in concert. Where the merger requires resources or capabilities to be leveraged between the organisations then connections between the combining organisations will be required. This involves changing the boundaries of both firms as people and technology that resided in each firm are opened up to the new partner. As the level of interdependence between organisations increases the distinctiveness of each as a separate entity decreases and the boundaries that separate them become blurred or are eliminated. In contrast, if the merging organisations are concerned with diverging markets and technologies, little interdependence between them is needed and the organisations can maintain existing boundaries, separate and distinct from one another.

### 2.4.2 *Organisational Autonomy*

Organisational autonomy relates to the degree that organisations must operate independently post-merger to deliver on the strategic objectives and is a function of the need to ensure strategic capabilities are preserved (Haspeslagh and Jemison 1991). Often capabilities are embedded within the distinct organisation and culture of the acquired company and changes to that organisation and culture may deplete or destroy those capabilities. The need to protect capabilities may arise either from the unique manner in which they are combined in the acquired or because those skills are not understood or present in the acquiring company.

### 2.4.3 *Integration Approaches*

Haspeslagh and Jemison (1991) combine these two dimensions to create a matrix that suggests four types of acquisitions integration approaches are possible. This thesis is concerned with two of these integration approaches, symbiosis and absorption, because these approaches require high levels of post-merger integration and changes to the boundaries of the organisation. In both cases the boundaries of each organisation must (although over different time frames) be adjusted to create a new organisational form that incorporates both previous organisations. In practice these integration approaches are archetypes and the distinction between each category can be problematic, although, in both cases high levels of post-acquisition integration are required. In holding or preservation integration the organisations are deliberately kept apart and require little or no integration as a result. Boundaries will not be problematic because there will be little or no transfer across the existing boundaries of the organisations.



Table 2.1: Acquisition integration approaches (Haspeslagh and Jemison, 1991)

		<i>Need for Strategic Interdependence</i>	
<i>Need for Organisational Autonomy</i>		Low	High
	High	Preservation	<b>Symbiosis</b>
	Low	Holding	<b>Absorption</b>

An absorption approach is appropriate when there is a high need for interdependence and low need for autonomy. Absorption implies that the acquiring and acquired companies are fully consolidated over time resulting in one single new entity that incorporates both firms. The key integration issue is the timing and sequencing of how the combining takes place. Value is likely to be created through the creation of resource and/or skills sharing so the speed with which these can be combined will be important for value creation. An absorption approach requires the boundaries of at least one of the organisations to change as a new entity is developed.

Symbiotic approaches arise when both the need for integration and the need for autonomy are high. Haspeslagh and Jemison (1991) suggest that symbiotic integration involves the coexistence of the two firms with the gradual development of interdependent activities. The boundaries of both organisations must initially be kept intact to protect the capabilities of each. Simultaneously the boundaries need to be permeable for the transfer of skills to occur. This is likely to involve a complex process of preserving the status quo while building frameworks for co-operation and an atmosphere suitable for capability transfers



to occur. Integration can only occur when both organisations understand and have adjusted to the characteristics of the other.

#### *2.4.4 The Level of Success in M&A*

Outcomes in M&A vary, perhaps reflecting the myriad of motives (Angwin 2007a) and the complexity of defining success. Failure rates between 45 – 70% have been reported in studies undertaken in the US and UK. Defining success is however not an easy task. The definition of success will depend on the research orientation and tends to mean different things within different fields. Financial economists focus on the share price movement during an event window or other financial measures, such as return on investment, market share or earnings. Financial measures tend to suggest that M&As perform poorly (Selden and Colvin, 2003; Datta and Puia, 1995 Hall and Norburn 1987) often suggesting failure rates as high as 70-80% of acquisitions.

In contrast Kitching (1967,1973, 1974) rejects financial measures of success in favour of the strategic expectations of management in the acquiring company. He argues that success should be measured against strategic objectives comparing current satisfaction levels against the original motives. Perceptual measures of success have become an often-used measure by those assessing M&As from a strategic perspective. Similar to the financial literature, strategy based research in the M&A field suggests failure rates of around 50% (Kitching, 1973, 1974).

Another way of assessing performance is by looking at the various stakeholders in the transactions and assessing their objectives. Angwin (2007a), for instance,

sets out a very broad range of possible motives for merging ranging from traditional institutional motives to exploration, political and survival motives. He argues that multiple motives often exist within a merger across firm-level motives, top management motives and contextual motives. A number of specific stakeholder objectives have been used as measures of success. For instance, human relations and organisation development practitioners have emphasized the impact of M&As on the human aspects of work, arguing that human skills are central to the creation of sustainable competitive advantage and that success should be considered in terms of how the human capital is managed and leveraged. Hence we have assessment of top management retention (Angwin, 2000; Hayes and Hoag, 1974), employee stress, (Marks and Mirvis, 1998) and cultural compatibility (Cartwright and Cooper, 1997). Similarly identity theorists have shown how low levels of identification with the post-merger organisation can lower performance and create conflict (Terry 2001; Buono and Bowditch, 1989).

In recent years increasing attention has been focused on integration as a key explanation (Stahl and Mendenhall, 2005) of merger outcomes. Regardless of the quality of the planning in the decision stages nothing can be realised unless the implementation runs according to that plan. There is significant evidence to suggest that the integration stage is often underestimated and mismanaged by the acquiring company (Marks and Mirvis 1998). A Coopers and Lybrand (1992) study suggested that acquisition failure was attributed to poor post-acquisition planning in 80% of cases. Smith and Hershman (1997) reflecting on their practitioner experience suggest that effective post-merger management

programmes improve the odds of success by 50%. Ravenscraft and Scherer (1989) suggest that implementation difficulties play a significant role in the subsequent performance of the firms, while Shrivastava (1986) suggests that one third of failures are a direct result of faulty integration. More importantly it is argued that the integration stage is where the actual value within the acquisition is created (Haspeslagh and Jemison, 1991) and accordingly is where management attention should be focused in order to realise the potential value of the transaction.

It is clear from this discussion that M&As often result in sub-optimal outcomes and the performance, by whatever measure, is often lower than anticipated. The study of M&A is therefore a worthy activity and more research is needed to help improve merger outcomes. This thesis specifically addresses this task and the research question relates boundary management to successful outcomes in practice. It is important therefore to define clearly what is meant by success within the integration task.

#### *2.4.5 A Working Definition of Success*

This thesis is concerned with the integration of organisational units. In this respect success can be defined in terms of the reason the integration is being undertaken, and operationalised as achieving the stated strategic goals of the organisation for the integration in line with the philosophy of Kitching (1967, 1973, 1974) and the broader stakeholder perspectives (Angwin, 2007a).

This is an appropriate measure because integration is concerned with the delivery of the goals and because the integration task (as will be discussed later) is



directly related to the goals established for it. Financial measures in particular are poor assessments for integration as many other factors, such as competitive environment, can also influence financial performance. Studies that increase the potential for improving M&A integration are important both in terms of extending the theoretical understanding of integration but also delivering improvements in practice. The thesis will make a contribution in these two areas. The next section will explain the integration phase in order that the management challenges in delivering the necessary level of integration can be explored.

## **2.5 M&A Integration**

This section explores the integration task faced within an M&A. Shrivastava (1986) provides a useful framework for exploring different aspects of the integration process. He suggests three levels at which integration needs to take place. The procedural, the easiest to integrate, is concerned with the creation of a single legal and accounting entity. The physical is concerned with merging the tangible assets, systems and technologies of the combining organisations and finally, the managerial and sociocultural level concerned with the integration of the culture, values and management philosophies.

### ***2.5.1 Procedural Integration***

Procedural integration combines the systems and procedures of both organisations to align the operating, management control and strategic planning systems of the companies and to create standardised work practices. When the basic operating and control tasks of the combining entities are aligned then the organisations will be in a better position to communicate and co-ordinate their



activities. They will speak the same organisational language because they collect and analyse similar information and have a common framework for decision making and decision justification. Procedural integration will aim to eliminate conflicting systems, rules and procedures and reduce the costs associated with collection, processing and communication of information. The most common procedural system that requires integration is the accounting and control system which is often the first (and immediate) change an acquiring organisation implements.

### *2.5.2 Physical Integration*

Physical integration involves the combining of the resources of the organisations to eliminate duplication and to foster sharing of resources. Physical integration is usually associated with economies and efficiencies of scale. Physical integration is often problematic as it requires major disruption to one or both organisations and involves the destruction and rebuilding of a firm's resource profile. Typical assets to be combined might include properties, production lines and products, technologies and human resources. While this integration task seems relatively simple on paper there are often many problems encountered in practice. Not all assets prove to be as easy to share as anticipated. Similar production technologies, for instance, may be used in quite different ways in each organisation or it may be discovered that disaggregating and recombining bundles of assets may result in the erosion of the value embedded in the original organisation structure.

### 2.5.3 *Managerial and Sociocultural Integration*

Managerial integration involves the intangible activities associated with managerial capability, strategic direction and culture. It involves creating leadership, commitment and motivation arising from the formation of a new top management team to lead the new entity. Selection of personnel and the retention of management talent in the newly formed organisation can be a significant challenge (Angwin, 2000, Marks and Mirvis, 1998). Managerial and sociocultural integration can be developed through personnel transfers between the two companies, fostering an environment of communication and idea exchange and developing transition structures or interim organisation structures (Daniel and Metcalf, 2001; Galpin, 2000).

Shrivastava (1986) considers sociocultural integration as merging organisational frames of references (Shrivastava and Schneider, 1984) arguing that merging firms often possess different and conflicting frames of references. Managers have different mental maps of the world and different ways of formulating, understanding and acting on organisational issues or problems. Integration must therefore build a common framework of understanding within the new entity and ensure that all its members hold the same basic organisational assumptions.

Shrivastava (1986) points out that this usually takes a long time to achieve and can only occur through the processes of socialisation and mental readjustment among managers. Many academics and practitioners have addressed similar issues under the heading of cultural compatibility (Love and Gibson, 1999; Marks and Mirvis, 1998; Cartwright and Cooper, 1997, 1995;) and acculturation theory (Nahavandi, and Malekzadeh, 1988) suggesting that it is a significant

reason for merger failure. Shrivastava (1986) also considers the need to create integration along a commitment and motivation dimension. He argues that the impact of an M&A on morale is generally negative and integration must create a positive force to overcome this problem. Improvements in reward and career opportunities should combine with open communication to foster a participative environment. He further argues that clear lines of authority and strong strategic leadership must be created early in the process.

#### *2.5.4 Task and Human Integration*

Birkinshaw, Bresman and Hakanson (2000) consider integration as consisting of two dimensions which while interrelated are also capable of being managed independently and pursued at different speeds. The first of these, task integration, is concerned with the transfer of capabilities and the realisation of resource sharing opportunities. The second, human integration, involves the creation of shared identity, employee satisfaction and co-operation. They argue that these two dimensions do not necessarily occur concurrently and that an organisation can place a relative emphasis on either one at a point in time. Given that task integration and human integration require predominantly different management actions (combining and eliminating operations versus building an atmosphere of mutual respect and trust) and focus on different objectives (operational synergies versus employee satisfaction), it is not surprising that one dimension can be pursued with little concern for the other. Eventual success is a function of the two parallel processes. However each process may have a negative influence on the other, for example an emphasis on generating task efficiencies may result in a loss of employee morale and motivation. Integration efforts must therefore



balance both dimensions to achieve an effective outcome. Birkinshaw et al (2000) point out however that these can be attended to at different times and suggest that risk-averse managers will first attempt to integrate the human aspects of the acquisition before the task aspects as a better way to achieve success.

## **2.6 Challenges in Post-Acquisition Integration**

Sections 2.5.1 to 2.5.4 have explored M&A integration showing that integration must occur at the human and task level and across procedural, physical and sociocultural aspects of the organisation. This section will explore the M&A challenges that might arise within these areas to achieve the appropriate level of integration. The aim of this section is to identify the types of actions management must engage in to deliver successful outcomes.

Problems in the M&A process can emerge from the context of the merger (pre-merger demographic factors) and from consequences of actions taken (or not taken) by management during the M&A process. The following sections will explore these problems as a means of understanding the management interventions that are required during the integration phase.

### ***2.6.1 Pre-integration Factors Impinging on Integration Outcomes***

Pre-acquisition factors emerge from the structure and organisational characteristics of the individual firms. Pre-acquisition factors such as relative size of acquirer to acquired (Kitching, 1967), acquisition experience (Shanley,



1994), relatedness of acquisition (Lubatkin, 1983; Kitching, 1974), speed of completion and financial position of seller (Hunt 1988), have been related to the outcome of an acquisition. There is however a difficulty in relating pre-acquisition factors to outcomes in absorption and symbiotic acquisitions. A gap exists between acquisition planning (of which these factors are examples) and implementing the integration programme, usually characterised by a different group of managers taking responsibility for each part of the acquisition process (Angwin 2000). Where success can occur only through adequate integration, and this is a separate and independent part of the M&A process, then pre-integration issues can only have an indirect relationship to success, at best. Interestingly Hunt (1988) suggests that it is an error to assume that as the deal was successfully completed, then the cause of problems must be the post-acquisition stages. He prefers to consider the process as a whole and suggests that problems in one part will create a knock-on effect in other stages. He identifies three limiting factors that may create problems in the post-acquisition stage.

‘First, the health or lack of it of the seller establishes *expectations* in the both the buyer’s and seller’s negotiators which affect the nature of their analysis and negotiation. Secondly, the length of time the buyer and seller have to *understand each other* affects the entire process..... Thirdly the level of secrecy necessary during auditing and negotiating, affects the *expectations* of different levels of the sellers management and staff.’

(Hunt, 1988, p.10 – italics added).

The critical point is not the role of pre-acquisition issues in determining the chances of post-acquisition success; rather how the expectations and

understandings of what the merger means to the individuals within the organisations may be created by the context of the merger.

In addition, there is evidence that where organisations share common or compatible characteristics they may 'fit' together more easily (Datta 1991). The main issues considered in terms of fit have been strategic and operational consistency and cultural compatibility.

#### 2.6.1.1 Strategic Fit

Strategic fit refers to the degree of relatedness between the firms. Strategic fit is often considered from the point of view of diversification. Since related acquisitions offer greater chances of synergistic benefits, and economies are more likely to be in businesses where the acquiring management have existing knowledge and expertise, and increase the possibilities of transferring capabilities across the combining organisations, then it should be expected that these M&As ought to outperform unrelated acquisitions. The empirical evidence however does not provide the expected support. Lubatkin (1987) found no support for the relationship. Chatterjee (1986) found that shareholder gains were higher in unrelated acquisitions and Seth (1990) found no significant differences between value creation in related and unrelated acquisitions. These findings led Datta (1991) to agree with Jemison and Sitkin's (1986) contention that strategic fit while important is not a sufficient condition for superior acquisition performance.

### 2.6.1.2 Organisational Fit

Datta (1991) identified two aspects of organisational fit. Firstly, there is the reward and evaluation systems of the combining organisations. He argues that such systems define the terms of exchange between the individual and the organisation. Many differences are possible across firms, particularly in terms of remuneration, criteria for bonuses and variability and flexibility within the pay structures (Daniel and Metcalf, 2001). Variations between combining organisations or changes in the systems are therefore likely to have significant impact on the individuals and strongly influence post-acquisition performance. Datta's (1991) findings however failed to find any significant relationship between differences in the reward and evaluation systems of the acquiring and acquired firms and post-acquisition performance.

In addition Datta (1991) recognised the importance of managerial styles which he defined as comprising a number of factors, mostly related to organisational culture, including attitude to risk, decision-making approach and control and communication patterns. Differences in managerial styles can cause cultural ambiguity and lead to one or other (usually the acquirer's) culture dominating the other often resulting in the loss of identity, confidence or competencies within the acquired. Increased anxiety, distrust and conflict may result (Ivancevich, Schweiger and Power, 1987). Datta (1991) found strong support for a negative effect of differences in managerial styles on post-acquisition performance regardless of whether the combining organisations had high or low levels of post-acquisition integration.



### 2.6.1.3 Cultural Fit

Research has also examined the effect of organisational culture on post-acquisition performance (e.g. Cartwright and Cooper, 1997). Cultural impacts can be categorised under two headings, pre-acquisition differences and as a source of unanticipated problems or resistance during the integration. The latter difference will be dealt with in section 2.6.2.1. Pre-acquisition planning approaches suggest that culture can be assessed by acquiring companies to determine whether an appropriate fit is possible (Cartwright and Cooper 1997, Love and Gibson, 1999). Cartwright and Cooper (1997) for instance suggest that culture can be considered as a continuum and that cultural change may be possible in certain directions along the continuum but not in others. They argued that when an organisation with a more autonomous and less constraining culture acquires an organisation with a similar or less autonomous and more constraining culture successful integration may be possible. Movement in the reverse direction however is likely to be more problematic and result in a less successful integration. This type of cultural analysis is also present in much of the behavioural research that has been conducted (Marks and Mirvis, 1998; Carleton, 1997; Buono and Bowditch, 1989; Siehl et al, 1988). It suffers however from a number of critical problems. Firstly, culture is an elusive concept and the construct of culture applied in these works often assumes that it is tangible, measurable and identifiable. All three of these assumptions can be contested (Schein, 1992). Indeed many works either fail to define culture or use very limited dimensions to measure it. Secondly, research has indicated that the culture of organisations may not be readily identifiable and may be evident only after the acquisition has occurred. People's culture is so much a part of them and



their lives that they are unaware of it, unable to define or describe it, until it comes in conflict with or is placed in contrast to another culture (Hall 1959). It is only after the companies interact with one another therefore that the true nature of cultural differences may emerge. The final problem is the prescriptive nature of the assertion that cultural compatibility is a prerequisite for success. There may be many intervening factors that may influence the desire or willingness of the acquired to surrender its cultural values. This may occur when the acquired is in danger of closure, when the acquirer is more prestigious or the acquired is unable to muster sufficient resistance to prevent the acquirer imposing their will.

#### *2.6.2 Post-integration Factors Impinging on Integration Outcomes*

Post-acquisition problems generally arise from unanticipated events or conditions that were not predicted (or predictable) pre-acquisition. A substantial number of potential problem areas have been suggested in the academic literature (Stahl and Mendenhall, 2005; Marks and Mirvis, 1992, 1997a, 1997b 1998; Buono and Bowditch, 1989) and practitioner literatures (Feldman and Pratt, 1999; Galpin, 2000; Daniel and Metcalf, 2001) many of which direct attention to human or cultural aspects of the integration process. In a way perhaps this should be expected as the task of integration ultimately revolves around the combining of people and the corresponding change in their behaviours and attitudes. Post-acquisition challenges can therefore be examined in terms of the managerial tasks associated with changing behaviour. Three issues are consistently reported as important to managing within the M&A environment:

1. Understanding identity and cultural processes;

2. Building momentum for change through power and politics;
3. The role of leadership and communication in the M&A process.

#### 2.6.2.1 Cultural and Identity Processes

Cultural compatibility between merging organisation has been related to the potential success rate in M&A integration (Cartwright and Cooper, 1997; Viljoen, 1987; Hall and Norburn, 1987). Cultural clash and cultural compatibility have been firmly established in the lexicon of M&As. Attention has focused on identifying and managing cultural elements of the combining companies emphasising issues such as how cultural due diligence (Carlerton, 1997) can be undertaken effectively, how education and communication can reduce the potential for conflict (Marks and Mirvis, 1998; Love and Gibson, 1999) and how identity changes create potential for resistance (Terry, 2001). Two specific aspects of culture require particular attention for the study of boundaries. Acculturation theory (section 2.4.2.2) explains how cultural conflict occurs when diverse cultures engage one another. Many of the conflicts that occur can be relate to boundaries and accordingly the theory sheds light on boundary conflicts and the management interventions to prevent them. Similarly, social identity theory (section 2.4.2.3) explains how groups codify intergroup boundaries as a means of maintain a separate social identity. Social identity theory has been used to explain intergroup conflicts in mergers and can be used to inform how boundary problems occur and how management interventions might alleviate those problems.

2.6.2.2 Acculturation

Acculturation theory is drawn from anthropology and explains how cultures change when two autonomous cultures come into contact, usually describing the reaction to the imposition of one culture onto another (Elass and Veiga, 1994). Acculturation follows three stages: contact, conflict and adaptation (Berry 1980, 1984). Contact is required because the combining groups need to be exposed to the culture of the other group and to learn about each other and themselves. It is in this stage that each will form perceptions about the other’s culture and assess the attractiveness of it. In boundary terms this represents the two boundaries of the organisations coming into contact and exchanges occurring across that boundary. Conflict occurs from the tension created by uncertainty as both parties respond to and develop from the cultural exchanges. At first the practices of the other culture may appear confusing, difficult to understand or unattractive. Over time however greater understandings may develop and an equilibrium reached that allows adaptation to occur. Adaptation occurs when an acceptable mode of acculturation is found for both parties.

Table 2.2 Acquired firm’s mode of acculturation

<i>Perception of the attractiveness of the acquirer</i>	<i>Degree to which acquired value their own culture</i>		
		<i>Very Much</i>	<i>Not at All</i>
	<i>Very Attractive</i>	<b>Integration</b>	<b>Assimilation</b>
	<i>Not at all Attractive</i>	<b>Separation</b>	<b>Deculturation</b>

Source: Nahavandi and Malekzadeh (1988) p.83



Table 2.3: Acquiring firm’s mode of acculturation.

<i>Degree of Relatedness of the firms</i>	<i>Degree of Multiculturalism</i>		
		<i>Multicultural</i>	<i>Unicultural</i>
	<i>Related</i>	<b>Integration</b>	<b>Assimilation</b>
	<i>Unrelated</i>	<b>Separation</b>	<b>Deculturation</b>

Source: Nahavandi and Malekzadeh (1988) p.84

Tables 2.2 and 2.3 suggest that acculturation can take four basic forms (Berry 1980, 1984).

1. Integration is based on the desire for unity and the tolerance of cultural diversity. Typically it involves the retention of both cultures and the autonomous coexistence of each. Some changes may be incurred by both as cultural elements are exchanged but neither group will dominate.
2. Assimilation is a unilateral process where one culture assumes the dominant position, replacing that of the other. The relinquished culture may be given up either willingly because of the attractiveness of the new culture or from coercion on the part of the dominant group.
3. Deculturation occurs when cultural and psychological contact is lost with both cultures and the group remains outside both. This occurs when feelings of alienation, loss of identity and acculturation stress develop.
4. Separation is based on the desire to maintain the existing culture by remaining separate and independent from the dominant group. This usually involves minimal cultural exchanges between the groups.

Sales and Mirvis (1984) demonstrated these processes in action when they considered the acculturation process of a manufacturing organisation with a major conglomerate organisation. They showed that the acquired company went



through a number of cognitive processes emphasising differences between the two companies, and the development of an ethnocentric perspective of events. Over time conflict gave way to an agreed balance between the demands of the acquiring and acquired organisations.

Nahavandi and Malekzadeh (1988) also applied this framework to M&As. They suggested that the course of acculturation depended on the way in which the acquired (table 2.2) and acquiring company (table 2.3) approached the implementation of the merger. From the perspective of the acquired company they will be concerned with the degree to which they want to retain their existing culture and how attractive they perceive the acquiring company's culture to be. Nahavandi and Malekzadeh (1988) suggest that these can be measured by asking members of the organisation the extent to which they seek positive relations with the acquired and the extent to which they value their own culture. From the acquired point of view the preferred mode of acculturation will depend on its tolerance of multiculturalism (degree to which it is willing to value, tolerate and encourage cultural diversity) and degree of relatedness involved in the diversification strategy. Nahavandi and Malekzadeh (1988) argue that when the acculturation mode of the acquired and the acquirer are congruent then acculturation stress will be minimised and the potential for successful post-merger integration will be greater.

#### 2.6.2.3 Social Identity Explanations

The Nahavandi and Malekzadeh (1988) framework was extended by a social identity approach adopted by Ellass and Veiga (1994). Social identity theory

(SIT) is a theory of inter-group behaviour that explains the way groups interact to differentiate themselves as a basis of creating social identity (Tajfel, 1970, 1972; Tajfel and Turner 1979, 1986; Turner, 1982, 1985; Turner et al 1987). SIT addresses the boundary debate because it ties inter-group actions to differences between the groups. Groups create self-image by bounding themselves. The cornerstone of the theory is the assumptions that individuals are motivated to create positive self-esteem and that they do this through membership of groups that provide them a positive value connotation. This positive value connotation is generated through the comparison of the membership group (the in-group) to another group (the out-group) on some grounds that favour the in-group. The implications for M&As is that when social identity is unsatisfactory, individuals will strive either to leave their existing group and join some more positively distinct group and/or to make their existing group more positively distinct (Tajfel and Turner 1986). In other words, if people are dissatisfied with their identity in the new organisation they will be motivated either to draw 'them versus us' distinctions that frustrate integration and drive the organisations apart or to leave. In-group and out-group membership has been shown to be important in defining group behaviour. To protect social identity individuals are motivated to support their group identity (Tajfel and Turner, 1986), give greater weight to information originating within the social group (Haslem, 2001; McGarty et al, 1993; Van Kippenberg et al, 1994), and will protect their group by differentiating themselves from others. M&As provide the precise conditions under which in-group and out-group conflicts are likely to occur.



Social identity effects have been reported in M&As (Kleppesto, 2005; Terry, 2001; Van Knippenberg and van Leeuwen, 2001). Terry (2001) for instance, considered the effects of high and low status groups on the level of in-group bias. Where in-groups are low status they found that the group will emphasis status irrelevant dimensions of the differences in the organisation. He identified a number of strategies for dealing with low status both at the individual (mobility) and group (collective action) levels. Van Knippenberg, and Van Leeuwen (2001) created the concept of entitativity, the degree to which the members of the organisation considered the new organisation to be a continuation of the old. They found that the level of perception of continuity increased the success of merger outcomes.

More broadly, Ellass and Veiga (1994) argue that acculturation outcomes are impacted by the extent to which groups wish to differentiate themselves post-merger. The greater the perception of dissimilarity in in-group and out-group behaviour the greater the strength of negative feelings in-group members are likely to feel. How perceptions emerge is therefore likely to influence the extent and nature of conflict that will emerge. Johnson et al (1984) suggest that the initial impressions are likely to form based on salient, observable behaviours visible in the early days of contact. A second factor influencing the desire for cultural differentiation relates to the status differences that emerge between the two groups. Perceptions of low status are likely to enhance differentiation (Moscovici, 1985). When the acquired organisation perceives itself to have lost status or to be considered as inferior to the acquirer greater value will be placed on the existing culture in an effort to maintain a positive self-image. The two

issues link to the process of sense-making (Weick, 1995). How organisational members observe, make sense of, and interpret what is happening round them creates perceptions of differences. This is an important distinction when considering how events develop in a M&A situation as there will be high levels of uncertainty, stress, anxiety and multiply conflicting clues about what is happening.

Both social identity approaches and acculturation theory show the importance of contact and awareness among organisational members during the integration. Contact and shared understanding are both the means by which groups can separate from each other as they enact differences or the process through which they can create a common bound to eliminate differences.

## **2.7 Power and Politics**

The second post-acquisition challenge emerges from the politics of organisational change. Political views of organisation emphasis the role power and politics play in organisation decision making and change (Hardy, 1996; Pfeffer, 1981, 1992; Pfeffer and Salancik, 1978; Pettigrew 1985, 1985b, 1979, 1975; Mintzberg, 1983). These views stand in marked contrast to rational explanations of organisation. They emphasise the conflict inherent in organisations and the political manoeuvring of individuals and sub-units. Conflict is inherent because organisations consist of limited resources and organisational members tend to have enduring differences on how those resources ought to be applied (Bolman and Deal, 1997). Organisational politics is not seen as a dysfunctional aspect of life but as the means by which preferences



are articulated and power mobilised to achieve those preferences (Bolman and Deal, 1997). The result is a dynamic process of tradeoffs between interested coalitions in an effort to maximise their desired outcomes. One of the critical benefits arising from the power and political literature has been the exploration of what power is. Traditional views consider power as a tangible facet of organisational life delineated by the formal hierarchy (Weber, 1947), with power or authority arising only from the position within the hierarchy. It became apparent however that power can be exercised in other ways including the potential to apply sanctions (Bierstedt, 1950), limiting or confining access to the decision arena (Bachrach and Baratz 1962), suppressing conflict (Lukes, 1974), the use of institutionalised norms and values (Lukes, 1974), the creation of social order (Foucault, 1977, 1984), and the unconscious acceptance of the values, traditions, cultures and structures of the organisation (Hardy, 1996). This underscores a shifting emphasis on understanding power as indirect and unobtrusive ways in which action can be influenced. While position (Weber, 1947), control of resources (Pfeffer and Salancik, 1978; Hickson et al 1971), information gate-keeping (Pettigrew, 1972), ability to reward (French and Raven, 1958), apply sanction (Bierstedt, 1950), or coerce (French and Raven, 1958) have been identified as critical sources of power there are several more intangible sources such as limiting access to the decision-making arena (Lukes, 1974), creating the decision framework (Pfeffer, 1992), creating values (Hardy, 1996; Pfeffer, 1992, Enz, 1986) or the enduring nature of tradition and custom (Hardy, 1996; Foucault, 1983). The critical issue with these unobtrusive factors is that they may operate on an unconscious level and in this regard are strongly tied to an organisation's cultural value system. Often power can be applied through

institutions (or organisational practices) which define acceptable behaviour for members. These institutional elements are defined by the dominant coalition in power and are often self-supporting and reinforcing.

### *2.7.1 Mobilising Power and Politics in M&As*

Post-acquisition management involves action, mobilising resources and people to achieve some end result. Integration therefore involves the generation and exercise of power. Combining firms are likely to have a context where diverse interests exist, different groups across functions and organisations fight to achieve their ends (or possibly just survive), and where uncertainty, complexity, stress, and lack of clarity prevail. At the individual level, people seek to reduce the impact of the M&A on themselves and generally become risk averse and protective (Marks and Mirvis, 1998). It is for these reasons that productivity often falls dramatically and organisational decision making disintegrates after an M&A (Marks and Mirvis, 1998; Buono and Bowditch, 1989). Resistance to the integration effort can therefore be seen as a natural response. Latent power may be released which resists integration, not necessarily out of disagreement with the integration objectives, but because of the political dynamics within the acquired company. In effect, M&A change becomes the fight to affirm political stability within the new organisation. There are positive and negative forces at play in any managerial action and change will succeed only when the positive forces are stronger than the negative forces (Lewin 1951). Mapping these forces can be a useful way of predicting opposition and redirecting forces to increase the chances of success. Lewin (1951) points out that the reduction of forces resisting change is a more effective strategy than increasing the pressure driving change.



Attention is better focused therefore uncovering the resisting forces. The issue of cultural clashes discussed earlier may be explained in terms of the political dynamics of organisation. Cultural differences represent a power base of resistance. Culture delineates the value bias of the dominant coalition and changing it involves changing the control of that group over the way organisational members see events. Boundaries are closely tied to the institutional structures that define acceptable and unacceptable behaviour and actions. The dominant political ideology can be expressed in terms of protecting a status quo and their position of authority, in other words bounding them from interference. Changes to the political system therefore strike at the heart of organisational boundaries.

## **2.8 Leadership and Communication in M&A integration**

A third challenge in M&A integration is leadership. There is a clear difference between leadership and management. Leadership is concerned with the creation of vision, providing inspiration and motivation, and the production of change (Kotter, 1990). Leadership is a forward-looking process (Nahavandi, 2000). In contrast, management is about planning, control, structures and predictability and the achievement of established targets (Kotter, 1990). Management is concerned with the present; leadership is concerned with the future (Nahavandi, 2000). The distinction between leader and manager is important. The M&A literature pays little attention to the distinction between managers and leaders suggesting only the need for clear leadership and vision to be present. Sitkin and Pablo (2005) for instance, recognise the neglect of leadership in M&As and Haspeslagh and Jemison (1991) identify a leadership vacuum as contributing to problems in the



integration. Haspeslagh and Jemison (1991) argue that leadership is required to help people from both firms to develop, understand and embrace the organisation's purpose and to see their role in it (p.132). Senior managers' (the organisation's leaders) attention to the acquisition often wanes however after the deal is signed and lower level managers are left to deliver results. Marks and Mirvis (1998) outline five central tasks as crucial to leadership during implementation. These are creating a vision for the combination, establishing integration principles and priorities, appointing senior managers, creating and leading the transition organisation and teams, and speaking to human purpose and understanding. A critical aspect of these tasks is the way in which the leader satisfies the need for staff to deal with the uncertainty and complexity of the integration process. Marks and Mirvis (1998) highlight a number of ways in which the leader can help the understanding of what is important for the combination. They argue that individuals are psychologically 'needy' for direction during uncertain times and that by creating a vision that individuals can buy into will help reduce uncertainty and focus attention on the achievement of long-term objectives. Marks and Mirvis (1998) also suggest that the first impressions given by leaders set the tone for the future. Employees are likely to evaluate senior management and draw inferences for future values and actions. They suggest that leadership decisions and actions send significant clues to staff and carry significant cultural messages. Factors such as the constitution of the integration teams in terms of functional orientation, acquired and acquiring staff, the number of senior managers, the level of authority given to the team, and perhaps the physical location of the team, may have symbolic messages as to the relevant importance of particular issues. For instance the domination of the team

by one set of staff may suggest to the other staff that they will be dominated in decision making.

Communication is a critical role of leadership and has been considered as an important part of the M&A process in commercial organisations (e.g. Pritchett 1997, Angwin, 2000) and in hospital settings (Shield et al, 2002). Practitioner literature in particular has emphasised the need for open and honest communication as a means to reduce uncertainty. A link between ineffective communication and stress has also been suggested (Marks and Mirvis, 1998; Ivancevich et al, 1987). An M&A generates significant disruption and stress due to the uncertainty it creates. Lack of clarity or ambiguity in the communications or insufficient communications may increase these levels of uncertainty. By increasing the amount, level and consistency of communication the uncertainty may be reduced. Buono and Bowditch (1989) argue that M&As place a number of additional demands on communication channels. Two types of communications are required: the first, to keep staff informed about the combination, its ramifications and its implementation and the second to facilitate getting the work done (tied to human and task integration). The message from these works is that communication must be of a sufficient nature in a timely manner and pervasive. Indeed many conclude that managers must communicate, communicate and then communicate some more (Angwin, 2000; Askenas et al, 1998)

The empirical evidence on M&A communication is a little more mixed than might be anticipated. Schweiger and DeNisi (1991) did find some empirical



support for increased communication lowering uncertainty among acquired staff but found no support for a link between communication and performance. Hogan (1990) argued that situational factors within the M&A would effect the level of information appropriate to the combination. She found a negative relationship between level of communication and extent of integration, with higher levels of communications in low-integration combinations and lower levels of communications in high-integration combinations. Greater levels of uncertainty exist in a high-integration combination and this led her to suggest that too much information may be problematic if it served to increase the level of personal uncertainty. The strength of the assertion that communication is a prerequisite for success is further questioned by Hogan and Overmyer-Day (1994) who suggest that the assertion is oversimplistic because of the multiple and conflicting goals that often exist within organisations. Managers have differences in motives and are likely to pursue actions of relevance to them and their position. Social identity theory has identified a referent information effect suggesting that the source of information will impact on the level of validity that recipients place on information. Information originating within the in-group will carry more weight than information originating from outside. Political issues are therefore likely to be important in determining the effects of a communication. Indeed, information can be considered as a source of power (Pettigrew 1972; Pfeffer, 1992) and how it is used can be critical in determining the strength of resistance to a decision. Communication has been defined as a strategic use of symbols to accomplish goals (Eisenberg, 1984) and accordingly communication within an M&A must be considered in terms of how it is designed to support political perspectives. While many advocates of communication openness call for the elimination of



ambiguity (Marks and Mirvis, 1998; Buono and Bowditch, 1989), the avoidance of specificity may, in certain circumstances, facilitate leaving future options open without fear of affecting trust or reneging on promises. In addition it may allow groups within the organisation to engage in a political dialogue in an attempt to clarify or institutionalise meaning into the communication. Hogan and Overmyer-Day (1994) also point out that the importance of communication is likely to vary for different organisational members. Those that are closest to control and decision making are likely to require more information than those at the periphery. Centrality of sub-units is a key factor in determining the power of that department (Hickson et al, 1971; O'Byrne and Leavy 1997). Access to information and communication could therefore be a more important issue to those who previously enjoyed greater access than for those who did not. Reduced levels of information could result in either an attempt at resistance and hostility toward the acquirer or the potential to realign the existing power structures. There are also differences in communication needs in the management hierarchy. Senior levels require very different information than factory operatives. Angwin (2000) considers communication in terms of the variety of interested groups (internal and external) and creates matrices which chart the variety of communication modes and the various interest groups. This acknowledges the variety, complexity and need for diversity in communicating to the various interest groups. Hogan and Overmyer-Day (1994) concluded that the blanket emphasis on open communication has failed to account for the variation within organisations.

Leadership is therefore an important part of establishing the future, reducing stress and uncertainty and creating an appropriate communication mix to drive the integration process.

## **2.9 Managing M&A Integration**

The previous section set out the challenges in integrating organisations after a merger. There are a number of management actions that can be adopted to attempt to reduce the incidence or impact of these challenges. Broadly the foregoing discussion has shown that problems emerge from:

1. pre-defined existing mental and behavioural schema that may emphasise disengagement and separation over integration based in cultural, political or experiential practices;
2. the potential for individual characteristics such as stress and uncertainty to influence the context of the integration and reinforce previous behavioural routines thus reducing the effectiveness of cross-unit understanding and communication;
3. problems combining physical organisational elements such as operating and regulatory systems;
4. process issues such as acculturation, social identity or sensemaking that emerge as the process of managing the integration unfolds.

It is clear that integration actions must target these problems if integration is to be successful. Substantial advice on the management tasks is available to practising managers (e.g. Hanson, 2001; Daniel and Metcalf 2001). While much of this work represents advice on good project management techniques a number

of specific interventions are identifiable that address directly the challenges identified above. While there are many ways of collating these works for the ease of classification they will be examined under three headings:

1. Contact and awareness building,
2. Training and developing of staff,
3. Building vision for the new organisation.

### *2.9.1 Contact and Awareness Building*

The stress and uncertainty inherent in M&A change often leads to dysfunctional consequences (Marks and Mirvis, 1997a, 1997b). Marks and Mirvis (1998) suggest that one way of removing uncertainty is to 'return control' to staff. By building awareness of events, providing communication, creating joint teams and sharing common understandings staff can be more confident about their position and are better placed to understand the changes occurring. Hubbard (2001) also emphasises awareness building as a means of creating a sense of justice. She argues that involvement of staff and being fair are critical success factors and that management should strive for quick and visible wins to demonstrate commitment and create buy-in.

Contact and awareness are components in the development of identity and culture. For instance, acculturation theory is based on contact as a first step in codifying and evaluating inter-group cultures (Nahavandi and Malekzadeh 1988, Sales and Mirvis 1984). Social identity theory also points to contact and awareness as necessary conditions of creating inter-group conflict (or by inference resolving it).



Creating contact and building awareness can therefore be an important tool for building understanding, reducing uncertainty and establishing positive processes of inter-group comparison.

### *2.9.2 Training and Behaviour Support*

The second intervention type has been called training and behaviour support to recognise the need to support individuals in the transition to new work structures, employment relationships and to build new behaviour routines (at both the personal and professional level).

Training can take many guises from the practical training of new skills and routines (Harper and Carmeraie 1995) to behaviour changing supports, such as relieving stress (Marks and Mirvis, 1998), emotional support (Kusstatscher and Cooper 2005) and even counselling (Marks and Mirvis, 1998). Training can be viewed as single-loop learning (how to perform a task) or double-loop learning (changes to the understanding of individuals). Within the context of this thesis training and behaviour support is defined as double-loop learning activities; the capacity to build learning routines for individuals so that they can engage more meaningfully (and reflectively) with the changes that they are encountering.

There is a fine dividing line between training as an awareness building activity (the previous intervention type) and the development of staff. This intervention type is intended to capture the latter.

Training is also an important symbol of investment in and just treatment of staff (Hubbard, 2001). Indeed, more generally, training support is a critical component of most change management programmes, particularly those that engage organisation development principles. Behaviour support goes beyond providing support for existing staff and often involves supporting staff who are exiting the organisation as a result of restructuring and might include early retirement counselling, retraining or job-seeking assistance. This can have important impacts on ‘survivors’ (Brockner, 1992) and their sense of justice (Hubbard, 2001).

Training and behaviour support is an important management intervention because it assists staff make the transition from old work and psychological practices to the new environment post-merger.

### *2.9.3 Building Vision for the New Organisation*

Providing leadership and vision is the third element of change in M&A.

Individuals seek meaning in change environments and effective leadership actions are central to many theories of M&A change (Buono and Bowditch, 1989; Marks and Mirvis, 1998; Pritchett, 1997) as individuals need a common sense of purpose and there is a need to align (Hubbard, 2001) teams to a unified agenda. Section 2.6.2.3 above highlighted the importance of providing leadership in order that the ‘psychological needy’ can be provided with direction (Marks and Mirvis, 1998).

Vision has been established as a key component in directing staff (Pfeffer, 1991) and creating the political momentum to foster change. Where change has been imposed (as is often the case in a M&A) then resistance may be a natural consequence. By codifying a vision individuals have the opportunity to buy into (or out of) a new future (Marks and Mirvis, 1998) and to identify with the new organisation (Terry, 2001). Building vision can reduce uncertainty, increase commitment and help to align effort.

**2.10 A Framework for Studying Boundaries in M&As**

This section brings together the management interventions discussed in section 2.9.1 to 2.9.3 and the categories of boundaries discussed in section 2.3.1 to 2.3.3. The interventions and boundary categories form a three-by-three matrix with nine potential impacts (table 2.4 overleaf ) The impacts have not been explored in the literature to date and while several works have addressed the importance of each intervention on overall merger success there is no existing evidence on how each intervention type impacts on the three boundary categories.

Table 2.4 links the boundary literature and the M&A literature and suggests a number of gaps in the knowledge where the two fields of literature intersect. These are represented by the grey boxes. The financial services study will explore these gaps. It will in the first instance expand on the boundary categories to establish what boundaries might arise in each category and then relate how the management interventions impact on those boundaries. This is a necessary prelude to building a theory that can be used in practice (the hospital study) as without an understanding of how management interventions interact with



boundaries, it would be impossible to theorise from particular actions to expected outcomes. Table 2.4 will therefore be expanded within the financial study (table 6.4 and 6.5), engaged within the hospital study (table 7.2) and confirmed within the findings (table 10.4).

Table 2.4: A framework for boundary management, linking boundaries and management interventions

	Physical Boundaries (section 2.3.1)	Behavioural Boundaries (section 2.3.2)	Cognitive Boundaries (section 2.3.3)
<b>Types of Management Interventions</b>			
<i>Contact and Awareness Building</i> (section 2.9.1)			
<i>Training and Behaviour Support</i> (section 2.9.2)			
<i>Building of a Vision</i> (section 2.9.3)			

## 2.11 Conclusion

This chapter has set out the theoretical foundations of the thesis by developing a model of M&A integration from a boundary perspective. Integration is a critical task within M&As and one that often results in sub-optimal outcomes. Exploring the issue from a boundary perspective is new and offers potential for emerging insights on how M&A outcomes might be improved. The theoretical framework adopted suggests that boundaries are socially constructed aspects of the work environment that differentiate one group or unit from another. They have physical, behavioural and cognitive origins and create integration problems by potentially driving and maintaining separation between groups. M&A literature



suggests that three management interventions may alleviate boundary problems, contact and awareness building, training and behaviour supports, and building vision. Combining boundary categories and intervention types suggests two critical questions in understanding the impact that boundary forming processes may have on integration outcomes, what boundaries emerge in M&A integration and how interventions impact on those boundaries. These two questions are the central themes in the financial services study.

## **3 Methodology**

### **3.1 Introduction**

This work examines how boundaries change during a merger and explores how boundary management can assist in combining previously diverse social groups into a new integrated one. An action orientated methodology is appropriate for undertaking this inquiry because of the need to ground the research and its findings in practical outcomes. This chapter will argue that the purpose of management research should be to deliver relevant research that is of ‘use’ to managers and that relevance is improved by conducting collaborative research with practitioners in an appropriate and rigorous manner in line with the philosophy of organisation development (OD). The chapter will establish the nature and practice of organisation development with particular emphasis on the development of theory within the field. As theory development is a key contribution, the chapter establishes a framework for developing and assessing theory. Theory can have different development pathways and assessment criteria across different ontological paradigms and these will be explored as a means of locating the methodology and of defining the criteria by which the outcomes of this particular research should be assessed.

This chapter commences with a review of the research objectives as these objectives drive the methodology decisions that need to be made. Stemming from the objectives the ontological and epistemological assumptions will be established before the theory and practice of action research is defined. The methodological implications of adopting action research for theory development



are then explored using Lynham's (2002) model of theory development in applied disciplines. The chapter ends with a set of criteria to assess quality within the process and output of the thesis.

The output of this chapter will inform assessments made in the conclusions, as to the strength and validity of the theory developed and of the quality of the process and outputs of the thesis. The chapter also informs the method decisions explained in the next chapter and establishes the philosophical position of the research (and indirectly the researcher) by laying out the work.

### **3.2 The Research Objectives**

The starting point in determining the research methodology is the research question. The research question guides the methodology and method by defining the outcomes and outputs that are required from the thesis and by implying sets of assumptions about the world and how it operates. This research is concerned with boundaries in a merger and how those boundaries change during a merger. The focus is to understand whether attempts to manage boundary changes can improve the post-acquisition climate and increase the level of post-merger integration. There are two distinct components to developing this understanding. In the first instance it is necessary to establish what types of boundaries may exist in a merger and how these change during a merger. This has been described earlier in terms of four questions.

1. How can we conceive boundaries and how can management act to impact on them?
2. What boundaries have the potential to exist during an M&A integration?

3. How do boundaries become salient during an M&A integration?
4. How can management support changes that create new boundary configurations in line with the objectives of the M&A?

While the literature review shows that no attention has been given to the specific role of boundaries in an M&A or more importantly how boundary problems arise, are resolved or become problematic. Chapter 2 did however provide a theoretical framework that defined broad categories of boundaries and grouped intervention types that management can adopt in attempting to change boundaries. The first research aims are therefore dedicated to deepening our theoretical understanding of boundaries and their impacts on the merger process and to developing a framework of boundary management that helps our theoretical understanding of boundaries in practice. This design is consistent with calls for more theoretical development of boundaries (Paulsen and Hernes, 2003) and more specifically for more inductive approaches that are grounded in first-order perceptions (Heracleous, 2004). The cumulative approach of generating knowledge from theory, fieldwork and practice will assist in meeting this call for more dynamic analysis of boundary phenomenon.

Following on from these questions is the more practical issue of, once we understand a theory of boundaries in mergers, how we can use that theory to impact on the post-merger position of the merged firms. This leads us to the core question of the research exercise:

## **How can we change boundaries during an M&A integration to improve the potential for success post-merger?**

This question extends the theory developed in the first section and, drawing heavily on the Lewin (1946, 1948, 1951) philosophy of ‘you don’t understand something until you change it,’ translates that theory into a practical solution for management intervention. One of the aims of the thesis in that respect is to provide practising managers with a robust framework which will assist in the more effective integration of organisations in a merger.

There are a number of ontological, epistemological and methodological assumptions embedded within the research question and the research aims. These will be explored in sections 3.3 and 3.4.

### **3.3 The Nature of the World and the Understanding of Knowledge**

Burrell and Morgan’s (1979) seminal work on sociological paradigms provide a useful way of addressing the twin fields of ontology and epistemology.

Ontology, the assumptions about the nature of the world, concerns the degree to which the world exists as an objective reality, separated from individual cognition. The ontological debate can be considered as a continuum where one pole (the objective view) argues that the world is made up of concrete structures and realities and the other pole (the subjective view) argues that reality is the projection of human imagination (Morgan and Smircich, 1980). The objective view adopts the paradigm of the natural sciences: that nature can be divided into reducible elements which can be examined objectively to determine



generalisable laws. Because the world is external to the researcher, and separated from the researcher, the researcher can remain detached from the object of study. In contrast the subjective view suggests that the world is created through the individual construction of that world in line with the practice, interaction and cognition of the individual. The world exists only in the eyes of the viewer and accordingly multiple realities exist.

Epistemological assumptions flow from the ontological stand. When a concrete world is assumed then that world is capable of being measured, it can be reduced to its component parts and the laws governing its construction and operation can be uncovered and codified. Furthermore these laws are capable of generalising the behaviour and operation of all similar occurrences of the event under study. Research is therefore conducted objectively and is external to the researcher. This approach is based on the western notion of scientific principles and is represented in positivistic models of research (see table 3.1). In contrast the subjectivist approach rejects the notion of one reality that is external to the person. Research in this paradigm concentrates on how the individual constructs the world through their interaction with that world and aims to explain and explore the phenomenology of events and how they unfold. The world can only be understood from the vantage point of the person who is engaging that world. In this paradigm the researcher is an integral part of the process of research and it is necessary to locate the researcher by uncovering their assumptions and their pre-understandings in conducting the research.



The positivist-interpretist divide has substantial implications for the design and conduct of the research programme, the validity of statements about knowledge and the determination of quality in the conducting of the research.

Lincoln and Guba (2000) outline the basic ontological, epistemological and methodological assumptions for various philosophical traditions. Table 3.1 replicates the major issues for the polar exemplars of positivism and constructivism. This table will be used as a means of explaining and understanding the research design.

Table 3.1: Comparison of *ontological* and *epistemological* positions

Issue	Positivism	Constructivism
Ontology	“Real” reality	Relativism – local and specific constructed reality
Epistemology	Dualist/objectivist; findings true	Transactional subjectivist; created findings
Methodology	Experimental/manipulative; verification of hypotheses; chiefly quantitative methods	Hermeneutic/dialectic
Nature of knowledge	Verified hypotheses established as facts or laws	Individual reconstructions coalescing around consensus
Knowledge accumulation	Accretion-“building blocks” adding to “edifice of knowledge”; generalizations and cause-effect linkages	More informed and sophisticated reconstructions; vicarious experience
Goodness or quality criteria	Conventional benchmarks of “rigour” internal and external validity, reliability, and objectivity	Trustworthiness and authenticity
Values	Excluded-influence denied	Included-formative
Ethics	Extrinsic-tilt toward deception	Intrinsic-process tilt toward revelation
Inquirer posture	“Disinterested scientist” as informer of decision makers, policy makers, and change agents	“Passionate participant” as facilitator of multi-voice reconstruction
Training	Technical and quantitative; substantive theories	Socialization; qualitative and quantitative; history; values of altruism and empowerment

Source: adapted from Lincoln and Guba (2000).



### 3.4 A Framework for Methodology

Based on the research questions this work has a number of meta-theoretical assumptions. These include

- 1) that the world is inherently a complex and ambiguous place where actions must be understood within the context of the person;
- 2) knowledge is situation-specific;
- 3) the world is a political rather than rational place;
- 4) people strive for certainty and order and
- 5) that the individual can and will influence the subjective world in which they live.

These assumptions suggest an epistemology that emphasises the way in which people make sense of the world and construct their subjective reality. The researcher needs to understand the role of context and the way in which the social interactions and individual constructions of reality impact on and shape the emerging changes. Constructionist approaches recognise that complexity causes difficulties in generating causal relations and that the world consists of mental constructs rather than concrete knowledge. In this manner the world is socially constructed as people seek out explanations for the unclear and ambiguous situations they face.

Recognising the need for a constructionist ontology, the research challenges are defined by reference to column 3 of table 1. These are the principal measures of research effectiveness that underlie the design and quality of the research.

Several fields of management study have addressed research questions from this



perspective. Two particular methodological issues are relevant to the research design. The first is the use of case studies as a mode of theory development. The second is how the broad field of organisation development (French and Bell, 1995) which includes such approaches as action research (Greenwood and Levin, 1998) and organisational learning (Senge, 1990) is appropriate as a means of researching complexity and incorporating rich context. The following sections will explore the methodological choices relevant to these two issues.

### **3.5 The Use of Case Studies in Theory Development**

The second pillar of the research design involves the generation of theoretical insights into what boundaries exist in an M&A and how management interventions might impact on these boundaries. A case study approach to building this theory is appropriate. Case studies have been shown to be a useful method of developing theory particularly in complex and political environments (Dyer and Wilkins, 1991). Typically case studies consist of detailed contextual analysis of a limited number of events (Dooley, 2002) so that a rich explanation of the phenomenon being investigated can be developed. They are appropriate strategies when, as in this instance, the research topic is conceived broadly, the research must account for multivariate conditions and it can incorporate multiple sources of evidence (Yin, 2003a p.xi). Case studies can be used either as a strategy of confirmation; that is a positivist research mode (Yin, 2003b; Eisenhardt, 1989b) or as an account of socially constructed reality (Dalton, 1959, Hawley 1995). This distinction is important in terms of what role the case study plays in contributing to knowledge.

Constructivist methodologies emphasise the subjective world in which we live and that knowledge is not concerned with facts or laws but rather with reconstructions that coalesce around consensus (Lincoln and Guba, 2000). In this respect traditional scientific notions of validity and generalisability do not hold. However, theory development within a constructive paradigm can inform and create paradigm changes (Dyer and Wilkins, 1991). By building rich accounts of individual contexts our understanding of that phenomenon is enhanced and our understanding of the links between theory and outcome, albeit within that specific case, is extended. Yin (2003a) refers to this as generalising to theory. This type of generalising is different to the positivist view of generating global laws rather it seeks to better understand how we frame action (our theories) in response to unique contexts. In this way we can build conceptual frameworks that guide our actions and allow us develop action-outcome expectations. Mintzberg (1979) referred to this in terms of a choice 'not between true and false theories but between more or less useful theories' (p.584)

At second issue that the case methodology must address is the level of induction that the case study should engage. Yin (2003a and b) suggest that cases are an appropriate way to both build theory and confirm theory. This dissertation is concerned with the former. Its purpose is to develop insights into a new area of study and it does this through the three pillars of the research, literature, fieldwork and practice. It is important within the division of these three activities to explain the relationship between them, particularly in the context of the development of the literature as a potentially *a priori* framework which could result in the case becoming more deductive than inductive. If this was to occur



the study would be more about theory testing than theory development. There are conflicting views about the timing of literature development within inductive case studies. Glaser and Strauss (1967) and Strauss (1987) for instance propose that the starting point for theory development is data and that the researcher should start in the field without *a priori* assumptions. In contrast Eisenhardt (1989b) argues that an *a priori* specification of constructs can help shape the design and improve data collection and Dooley (2002) suggests a good literature development stage helps to ground the research during the process of study. This study will follow the latter approach by developing an initial boundary framework to guide understanding within the research implementation. Cognisant of the constructive paradigm underpinning the research this framework is not a testable model but a statement of *a priori* understanding of boundaries. All action is guided by existing understanding so expressing this initial framework is an attempt at positioning this understanding. The case study is therefore not attempting to confirm the theoretical framework but to provide context to explore boundaries and to elaborate and extend our understanding of boundary phenomenon. To achieve this, the case study must not be confined by the framework through the implementation of an inquiry structure that reinforces the framework, i.e. it must allow for new theoretical insights. This can be achieved through two specific method design features.

1. The case inquiry will go beyond the framework by asking about the concept of differences rather than the boundary categories. Informants will not be asked directly about boundaries but will explore the issues of differences in a manner which will allow a more grounded uncovering of boundaries to emerge.



2. The capacity to build on the existing framework will be further enhanced within the data coding process. By starting with a free coding structure the opportunity for new categories of boundaries to emerge is presented. The coding design is to initially identify all the boundaries within the study and then to see how they can be categorised. In this way the theoretical framework developed in chapter 2 will not be imposed on the data.

### **3.6 Organisation Development as a Methodology**

The third pillar of the research design adopts an organisation development (OD) approach because of its ability to deal with complexity in practice, its recognition of the need to engage in collaborative enquiry and its strength as a tool of theory development through cycles of actions and reflection. These are important criteria in the study of boundaries which have been shown earlier to be complex phenomena. Organisation development as a cohesive field of study emerged in the 1940s from a number of seminal works such as Lewin (1946), Argyris (1974) and McGregor (1960). Throughout the development of the movement many ‘stems’ (French and Bell, 1995) of the discipline have emerged. For instance T-Groups research (Lewin, 1946), socio-technical systems (Trist and Bamforth, 1951), organisational transformations (Levy and Merry, 1986), organisational culture (Schein, 1992) several branches of action research (Reason and Bradbury, 2006) action learning (Argyris, 1993, 1999 Argyris and Schon, 1978, 1996) and the reflective practitioner (Schon 1983). All of these stems however share similar philosophical traditions and a set of common values and beliefs about the nature of research and change. French and Bell (1995) outline 10 major distinguishing

factors of the field of organisation development (p.33) which can be summarised into three thematic areas that drive the assumptions of, and theory development within the field.

1. Change is complex and is best studied and understood from a systems perspective. OD concentrates on processes and cultures recognising the complex social structures that exist and that change must occur with the totality of the system. OD usually takes place in action and engages interventions in organisational processes as a means of reflection and learning to achieve the 'betterment of both individuals and the organisation'
2. Change is brought about in collaboration with others across intra-organisation levels and within teams of people. The research leaders act as facilitators, collaborators, and co-learners with the client system.
3. Change is about sustainable learning and should result in the 'client system' being empowered to solve its own problems through cycles of continuous learning and inquiry.

The value of these assumptions is that they place the individual and their capacity to learn and develop at the forefront of organisational processes. In this respect OD and its many sub-branches, such as action research, are often associated with an emancipatory agenda which seek to enable individuals or groups transcend existing doctrine as part of the change process.

### 3.6.1 Systems Theory and Complexity

Systems thinking is at the centre of most OD methods. In dealing with human activity systems (Checkland, 1999) researchers engage the complexity of activities. An holistic approach is a core tenant of OD. The application of systems theory to organisation analysis emerged in the 1960s with the seminal works of Thompson (1967) and Katz and Khan (1966). A systems perspective considers organisations as *systems of interdependent activities linking shifting coalitions of participants; the systems are embedded in -dependent on continuing exchanges with and constituted by- the environments in which they operate* (Scott 1998 p28). This definition seeks to deal with the complexity of organisation life in a number of ways:

1. It considers the organisation in terms of the connectivity of actions within the systems itself and with those who exchange with the system. Interdependence creates cause-and-effect cycles throughout the system and creates intended and unintended outcomes. Systems theory also emphasises the need for external validity and resource acquisition (Pfeffer and Salancik, 1978) to ensure the continued survival of the organisation.
2. The definition also considers the shifting coalition of interests that make up an organisation and the sociopolitical environment within it (Pfeffer, 1981). This attunes to the dynamic nature of organisations as shifts in the make-up and perspectives of coalitions impact on the interrelated activities.



Another key assumption within systems theory is that open systems tend toward homeostasis, a steady state of equilibrium. This steady state does not mean that the system is static, quite the contrary, dynamic homeostasis arises from the system continually seeking to maintain an equilibrium by responding to internal and external disruptive forces. The system continues to buffer itself against variation by creating mechanisms to ensure stability.

French and Bell (1995) outline the implications of adopting a systems perspective as the basis of OD. By adopting a systems perspective OD explicitly recognises that no outcome is the result of an isolated incidence but must be viewed in relationship to other events and forces. Secondly, theory must develop multiple casual explanations rather than simple single casual explanations.

Thirdly, researchers and practitioners must understand that changes in one part of a system will influence other parts of the system. Fourthly, the focus of study should be the forces in the field at the time of the phenomenon, i.e. the analysis must be of a contemporary rather than historical mode and finally, implementing change requires changes to the system not just the components. Theory must therefore relate to the system rather than the components.

This view of change as holistic with multiple causes and affects informs the research design in a number of ways:

1. there is a need to create a meaningful context for the data;
2. greater understanding is created through multiple sources of data;
3. multiple perspectives need to be developed and explored to support multiple explanations of the phenomenon;

4. longitudinal approaches to research that incorporates past, present and future actions facilitate a deeper understanding of phenomena.

### 3.6.2 *Collaborative Management Research*

The complexity of M&A change requires a holistic research approach that develops understanding about the total system being studied and requires a variety of perspectives to be considered in order to enhance and challenge understanding.

While academic management research is conducted with many purposes in mind there are increasing calls to ensure ‘relevance’ of research to the world of practice. Several authors have suggested that academics are becoming ever more distant from the practitioners who must interpret and adopt theory into practice. Lewin (1946) emphasizes the importance of making use of knowledge to make social improvements and he firmly believed that research should fulfill the criteria of ‘usefulness to society’ and Revans (1971) criticised business education for fostering an artificial distinction between theory and practice, for becoming more and more distant from the realities of the business world and for proliferating irrelevant academic information. Researchers are also arguing that the distinction between theory and practice is artificial (Giddens, 1993), for instance Gibbons et al (1994) promote mode 2 research where knowledge production is linked to the ‘*context of application or use*’ (p.17) and Bennis and O’Toole (2005) argue that Business Schools have lost their way by following too scientific a model that distances itself from practice.

One way of ensuring relevance of research is to involve those who are the focal point and participants in the study and ensure that they are engaged in the co-creation of knowledge about the study. By combining the perspectives of both theoretician and practitioner greater insights can be achieved and a bridge between the understandings and perceptions of each category can be built (Shani et al, 2008). The purpose of this dissertation is not to resolve this debate or to give hegemony to one camp or the other. However, the thesis adopts the assumption that the understanding of complex phenomena is enhanced by the incorporation of a practitioner perspective and that the results are both stronger and more easily translated in practice if they are developed in a real practice setting. This view is strongly supported in an ever-increasing body of literature. For instance, Louis and Bartunek (1992), Bartunek and Louis (1996) and Bartunek (2008) outline collaborative efforts in research across a multi-discipline spectrum including community psychology (Bartunek, Foster-Fishman, and Keys, 1996), ethnomusicology (Diamond and Polansky, 1994<sup>3</sup>), education, (Cochran-Smith and Lytle, 1993; Goswami and Stillman, 1987), and organisational behaviour (Lazes and Costanza, 1984; Pace and Argona, 1991 ; Whyte, Greenwood, and Lazes, 1991).

The power of involving an insider team into the research design, execution and analysis is demonstrated by Bartunek and Louis (1996) who argue that:

*the deliberate and extensive harnessing of multiple, diverse perspectives to the task of inquiring and making sense of complex social phenomena*

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<sup>3</sup> Quoted in Bartunek and Louis (1996)



*can substantially enhance contributions to knowledge and practice*

*(Bartunek and Louis, 1996)*

According to them this enhanced contribution can be achieved by developing insider/outsider (I/O) teams. I/O teams consist of a collective mode of inquiry where organisational insiders and outsiders combine to jointly inquire, collect data and analyse findings. Jointly, they construct meanings about the world that make sense to both and have currency in both worlds. Typically, insiders are organisation members engaged with the social reality that is being studied. They see that social reality from the perspective of their theories in use (Schein, 1992; Argyris, 1999) or from implicit theories (Heider 1958) that allow them to make sense of their context and to act upon that context. In contrast, outsiders are external to the organisation and are objective observers of events concerned with general theories that explain social phenomenon. Branches of science, such as ethnography, have dispatched researchers to study local cultures by observation and understanding the 'native view'. These studies, typically, reflect the expression of a social order in terms of the understandings of the trained social researcher. By working together the insider and outsider can surface assumptions about each other's perspective, can challenge the understanding of each and can collectively incorporate building on the implicit social heuristics of the insider and the research inquiry perspective of the outsider.

Bartunek and Louis (1996) suggest that there will be two advantages to a collaborative approach. The first relates to the capacity of diversity to improve understanding. The differences in 'experience histories' of the co-researchers will act to generate more diverse conjectures, or "thought trials" to cover more

interpretive as well as observational ground (Bartunek and Louis, 1996. p.17).

There are clear differences in the inquiry modes of insiders and outsiders and their objectives in developing and assessing theory. Bartunek and Louis (1996) identify four distinctions.

1. The insider is concerned with the individual case and the resolution of a problem while the outsider is concerned with the development of theory capable of generalisation to a wider population.
2. The time span of action is more immediate in terms of the insider as they are often bounded by the time requirements of the tasks that they are required to complete.
3. Drawing on the work of Elden (1983) they note that organisational members are likely to attribute workplace problems to organisational arrangements, whereas outside researchers are more likely to attribute them to problematic people and technology.
4. Drawing on work such as Barley, Meyer, and Gash (1988) they suggest that the impacts of their theories on practice differ and that the development of practice based theories may have more impact on academics' theories than vice versa.

These distinctions create a tension between the objectives of the insider and outsider which, within a properly structured exchange, allows for richer exploration of social phenomenon.

The second advantage stems from what Bartunek and Louis (1996) called a 'marginal stance'.

*Marginal perspective is created at the intersection of the contrasting perspectives represented by insider and outsider. Neither party need be a marginal member of her[sic] respective setting; rather, as each engages with the relative foreigner who is her [sic] partner in the venture, that party's own world is made to some extent more foreign in her [sic] own eyes (p.18).*

In effect a marginal stance occurs because the insider becomes less connected to the social setting through the discourse of the outsider and they can as a result reflect more intensely on their understanding. For the outsider, the discourse with the insider provides insights into the social world that could not be achieved otherwise. Creating a marginal stance will greatly improve the capacity of researcher and practitioner to develop understanding and to create deeper clarity on the value of their findings.

### *3.6.3 Organisation Development and Sustainable Learning*

Organisation development is also concerned with fostering learning at multiple levels. While OD has developed a specific focus on organisational learning as a sub-discipline (Senge, 1990; Argyris, 1999), it is also an embedded assumption of all strands of OD that sustainable learning should occur as a result of research and interventions. OD approaches foster learning by uncovering the assumptions that guide action and behaviour and expose those assumptions to alternative perspectives and internal questioning. Argyris (1993) has suggested that learning occurs through the process of comparing expected outcomes to actual events and explaining the differences that occur. He has written:



*Learning occurs when we detect and correct error. Error is any mismatch between what we intend an action to produce and what actually happens when we implement that action. It is a mismatch between intentions and results. Learning also occurs when we produce a match between intentions and results for the first time (Argyris 1993 p.3).*

Learning can also occur at different levels. Argyris and Schon (1978) proposed a three-level model of learning where each level represented a deeper and more sustainable level of change. The simplest form of learning, they termed single-loop, to represent a unidirectional impact of error correction. Single-loop learning occurs when the learning is within the existing normative structures. Changes are achieved within the existing codes of behaviour, routines and assumptions of the individual. It will not lead to questioning of the assumptions or behaviours. In contrast double-loop learning moves beyond the correction of variance to challenge the assumptions on which the actions and expected outcomes are based. Double-loop learning will result in bidirectional learning in terms of the action-event cycle and in terms of the normative structures that guide an understanding of the action-event link. Typically, this learning will manifest itself in the changing of assumptions, goals or behaviour routines as individuals build greater self-understanding and awareness of their own basic assumptions and behaviour routines and how these relate to expected outcomes. A third level of learning involves changes to the very system in which the action-outcome event occurs. Triple-loop learning goes beyond the individual or team and impacts on the wider system in which the learning occurs. Typically, this will manifest itself in a radical realisation that that wider system needs to reconsider its '*raison d'être*' One way in which this often occurs is when the

learning that has been developed at the double-loop level feeds into a wider system understanding about how to learn and act and what role the wider system has in promoting learning. OD approaches, to be effective, require learning to occur at least in a double-loop manner.

### **3.7 Conducting Action Research**

Action research is one form of collaborative endeavour that combines researchers and practitioners in a cyclical process of action and reflects as an aid to improving both theory and practice. The philosophy of action research derives from the early work of Kurt Lewin and at its centre is a core assumption that social change can only occur through the involvement of individuals in the design, implementation and reflection on the social change agenda. Argyris (1993) summarised the four core themes of Lewin's work. Drawing on this Coghlan and Brannick (2005, p.9) suggest Lewin

1. integrated theory with practice by framing social science as the study of problems of real life and connected all problems to theory;
2. designed research by framing the whole and then differentiating the parts;
3. produced constructs that could generalize and understand the individual case, particularly through the researcher as intervener and his notion that one could only understand something when you tried to change it;
4. was concerned with placing social science at the service of democracy changing the role of those being studied from subject to client.

Altrichter (2002) has pointed out the complexity of defining action research as it can be *applied in many settings and across different cultures*. This complexity is

evident in that while many action researchers attempt to tightly define what action research is, others prefer to define when it is appropriate. As indicated earlier, there are a number of key characteristics that define action research and which form the basis for most definitions. Coughlan and Coughlan (2002) for instance suggest that four broad characteristics define AR:

1. Research *in* action rather than research *about* action (to be in action it must operate through a cycle of consciously and deliberately planning, taking action and evaluating the action, leading to further planning and so on);
2. Participation by those involved in the phenomenon;
3. The research is concurrent with action;
4. A sequence of events and an approach to problem solving that:
  - a. is a sequence of events consisting of iterative cycles of data gathering, feeding them back to those concerned, analyzing the data, planning action, taking and evaluating that action and moving to a new cycle;
  - b. is problem solving applying a scientific method of fact finding and experimentation to practical problems requiring action solutions and involving the collaboration and co-operation of the action researchers and members of the organisational system;
  - c. is not just solutions to the immediate problems but important learning outcomes both intended and unintended, and a contribution to scientific knowledge and theory.



In contrast, Altrichter et al (2002) reported on the development of a working definition of action research developed by participants at an international symposium on action research.<sup>4</sup> The outcomes of the decision created a definition that defined whether a research activity constituted an action research activity. Table 3.2 presents this definition.

Table 3.2: The action research process

If yours is a situation in which	
	people reflect on and improve (or develop) their own work and their own situation
	by tightly inter-linking their reflection and action and
	also making their experiences public not only to other participants but also to other persons interested in and concerned about the work and the situation, i.e. their (public) theories and practices of the work and the situation;
and if yours is a situation in which there is increasingly,	
	data gathering by participants themselves (or with the help of others) in relation to their own questions;
	participation (in problem posing and in answering questions) in decision making;
	power-sharing and the relative suspension of hierarchical ways of working towards industrial democracy;
	collaboration among members of the group as a “critical community”
	self-reflection, self-evaluation and self management by autonomous and responsible persons and groups;
	learning progressively (and publicly) by doing and by making mistakes in a self-reflective spiral of planning, acting, observing, reflecting re-planning etc.
	reflection which supports the idea of the “(self)-reflective Practitioner ”
then	
	yours is a situation in which action research is occurring.

Source: extract from Altrichter, Kemmins, McTaggart and Zuber-Skerritt (2002 p.130)

It is clear from these definitions that action research is concerned with the involvement of participants to design, implement and reflect on the ongoing process of change in order to improve both the practice that is being studied and the theory underlying that practice. In this respect the researcher and the practitioner work together to influence outcomes and understandings both sharing and reflecting on their lived experiences of the events being studied. As collaborative research this increases the opportunity to test understanding by

<sup>4</sup> The first international symposium on ‘Action Research in Industry, Government and Higher Education’ Brisbane 1989.

incorporating greater diversity of perspectives, providing greater voice to participants in the research and increasing the opportunity to reflect and test theory development.

There are many variations of action research that translate action research principles into a change framework (Herr and Anderson, 2005; Whitehead and McNiff, 2006; Gummesson, 2000; French and Bell, 1995; Schein, 1987, 1988; Lewin 1958). Indeed AR has been used extensively as a methodology in healthcare research (Coghlan and McAuliffe, 2003). All approaches are consistent with the principles and philosophy of action research but differ somewhat in the stages of application. Generally, they suggest a process that starts with a pre-evaluation and is followed by ongoing cycles of diagnosing, planning, acting and reflection (Coghlan and Brannick, 2005). The central thrust of inquiry in action research is the process of action-outcome-reflection leading to new cycles of action-outcome-reflection. This is often shown as a cyclical process of consecutive cycles where the reflections on outcomes lead to changes in practices and understandings and the initiation of a new cycle. This is represented in figure 3.1. Coghlan and Brannick (2005) also point out however that there are many action research cycles operating concurrently at any one time. The overall project cycle will be supported by shorter time frame actions, such as individual parts of the project which in turn may have shorter time events such as individual meetings. They liken these cycles to a clock with hour, minute and second hands, all operating concurrently but also contributing to each other's cycle. As well as the cycles of action and reflection, there also exists a parallel cycle of meta learning (Coghlan and Brannick, 2005). The meta-learning

component extends beyond the need to achieve practical outcomes from the research process to explore what has been learned from undertaking the research project. Mezirow (1991) defined three forms of reflection that Coghlan and Brannick use to develop their AR model. Content reflection concerns the understanding of what has happened, process reflection considers the way in which the research is executed and premise reflection assesses the underlying assumptions and theories. In respect of the examination of boundary management in a merger, the meta learning needs to address the new theoretical insights that have emerged from the actions, from the application of the theory development process (specifically the use of the AR methodology) and also in terms of our theoretical understanding of boundary phenomenon in mergers.

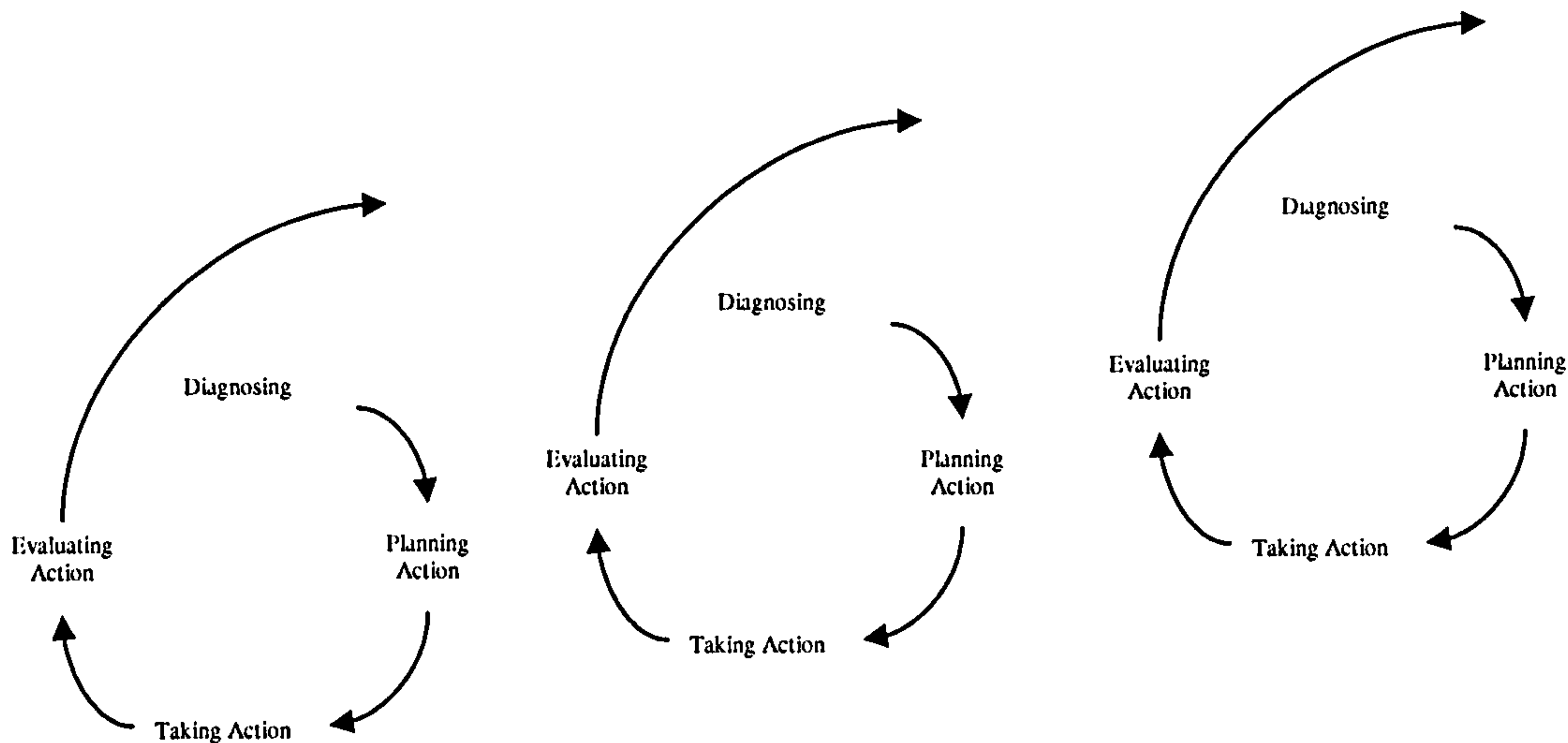


Figure 3.1 Spiral of action research cycles (Coghlan and Brannick, 2005)

### 3.7.1 Stages in the Action Research Cycle

The action research process starts with a diagnosis stage. This stage sets the context and uncovers some of the assumptions and theories in use that apply in a



particular issue. The stage involves clearly articulating the issue through appropriate data collection and through engagement with the issue owners. This stage will 'frame' the issue. It is important that the framing stage is collaborative and is sensitive to the social and political realities that exist in the organisation. The output of the diagnosis phase should be a clear shared understanding between all the participants as to the nature of the issue being acted upon, the awareness of the assumptions about the issue and the desired outcomes that any intervention would bring about.

The second stage in the cycle is the planning stage which should be designed to translate the knowledge about the issue into a set of actionable interventions that will lead to the desired outcomes. This stage will likely determine the need and urgency of the changes and to define and codify the outcomes that are expected from each intervention planned. Collaboration is a critical part of this process as participants through the process of discussing the issue can create a common shared vision of actions (Fischer and Ury, 1986) and can build greater understanding about their own and other's assumptions (Bartunik, 2008). By planning action collectively greater commitment to the implementation can be created.

Once the planned actions are designed the next stage is to implement the agreed action. The primary difference between consultancy and action research is evident particularly during this stage. Consultants are interested in the relationship between action and results. Action researchers are concerned about understanding both the outcomes achieved and also the process of how those

results came about. This stage is therefore concerned with systematic data collection on what is happening, continually testing of the assumptions of the participants and the continual evaluation of the value of interventions.

The final stage in each action research cycle is reflection. This stage compares the actual outcomes, assessed through perceptions, group discussions and evidence collected through appropriate data collection techniques, against those anticipated at the start of the process. Errors and variations can then be highlighted, as can confirmatory outcomes that support theoretical insights assumed at the commencement of the cycle. Errors, variations and confirmations can then be considered and the research and the collaborating group can discuss these to continually evaluate the assumptions, values and insights that initiated the original action cycle. Reflective practice is the key component of these assessments.

### **3.8 The Role of the Action Researcher**

In collaborative research the researcher and the focal organisation collectively engage with issues and jointly act to improve organisational outcomes and processes. In this respect it is important to define what roles each party plays in the collective effort and more importantly to define the nature and boundaries of that relationship. The strength of collaborative effort is that by helping each other the researcher and practitioner can create greater insights (Bartunek and Louis 1996). Helping, however, can take many forms. Schein (1999) for example identified three forms of helping. The first he called the 'purchase of information model' which involves the client system buying an expert service from a

consultant. In this model the client defines the need and the consultant provides the solution to the client's specifications. The second category of helping Schein (1999) referred to as the 'doctor-patient' model. Here the consultant/researcher is an expert who is engaged to evaluate the organisation, diagnose the problem and provide a solution. This model presents the consultant with significant authority and power as they become the oracle through which the organisation can resolve their problems. It also removes the responsibility for diagnosis and change from the client company reducing the ability of the organisation to learn. Schein (1999) called his third model of helping 'process consultation'. He defined this as "the creation of a relationship with the client that permits the client to perceive, understand, and act on the process events that occur in the client's internal and external environment in order to improve the situation as defined by the client" (p.20). Process consultation focuses on the way in which the researcher and client relate to each other in process terms. Schein (1999) notes "the emphasis is on "process" because I believe that *how* things are done between people and in groups is as-or more important than-*what* is done" (p.3). This also links to Stringer's (2007) notion of the action researcher as a 'resource person' existing as a catalyst to assist stakeholders in defining problems and supporting them in working toward solutions (p.23) and to Greenwood and Levin's (1998) 'friendly outsider' and to Gummesson's (2000) change agent. The assumptions underlying a process mode are:

1. People need help in diagnosing problems but they must always 'own' the problem;
2. Practitioner do not always realize what help they need (or is available) in process terms and must be guided on appropriate models of helping;



3. An organisation's desire to improve performance can be enhanced if they build learning capacity and it is the role of the action researcher to help in this regard;
4. Only clients will know what will work in their organisation and therefore the action researcher must work with the practitioner to jointly agree actions if they are to be useful. Outcomes are improved if the focal organisation develops diagnosis and learning skills that help them to take ownership of issues and implement their own remedies.

The process role underpins the action research philosophy of this dissertation. While the overall purpose of the study is to develop usable theory on boundary management it is important none the less to realize and plan for the impact the action research role could have on the hospital. Indeed Coghlan and Shani (2005) suggest that action researchers should consider the critical issues of roles, politics and ethics in the design of action research. They highlight the dilemmas that action researchers may face in the design and execution of projects. They draw on Katz and Kahn's (1978) notions of role conflict and role ambiguity to explore some of these dilemmas. Role ambiguity arises where there is uncertainty about what the role holder is to do. This can easily arise within an action research project where the expectation of the researcher and practitioner in terms of their respective roles is unclear or even at odds. Schein's (1999) descriptions of helping roles provide a clear example of this issue. Schein notes "the helper must choose from one moment to the next, which role to be in or which model of helping to use (p.5). The helping role shifts from time to time and it is not always clear which mode of helping is expected or appropriate (Gummesson, 2000).

Similarly ambiguity can arise in terms of the expectations of doing. As the action researcher can be called upon to act in several capacities within any project such as researcher, supporter, expert, facilitator and so on, there is always potential for different expectations about these roles to emerge. Herr and Anderson (2005) also suggest that role problems are considered in the research design from the beginning. Research designs must accordingly recognize the potential for role ambiguity and to attempt to resolve or at least allow for it within the relationships of the collaboration. The most obvious way of achieving this is to ensure an appropriate letter of engagement is drafted that addresses the role responsibilities of each member of the team (see section 4.3.1 for discussion on this in the hospital and appendix 4 for the letter of engagement).

Coghlan and Shani (2005) also identify role conflict as a central problem in conducting action research. Role conflict was defined by Katz and Kahn as “the simultaneous occurrence of two or more role expectations such that compliance with one would make compliance with the other more difficult” (p. 204). Role conflict occurs because the action researcher often must balance different roles. Action Research is designed to contribute to the client system but also to contribute to science Gummesson, (2000) for instance, suggests that “action scientists must be able to balance a Schizophrenic personality and get the best out of Dr. Jekyll as well as Mr. Hyde. It means that they must handle both the client’s interests and the interests of science” (p.119). The action researcher is simultaneously, an organisation resource supporting the learning of the organisation, a researcher with the obligations of publishing and possibly a support mechanism or trusted confidant to individuals or groups within the



organisation. Events can often bring these issues into conflict, as for instance when theory development casts doubts over existing practices and reflects poorly on individuals. Given the emergent nature of action research, it is difficult to completely resolve role conflict at the outset. The development of an appropriate resolution framework in the initial agreement letter is clearly a starting point. However, it must be anticipated that a number of ethical or professional dilemmas are likely to occur within any action research project. Perhaps however the most effective way of planning for role conflicts is to develop a strong ethical and professional practice. The philosophy of action research supports a strong emphasis on openness, trust and democracy. Applying these principles suggests that the action researcher needs to understand when role conflict is emerging and then to position themselves in relation to the conflict by discussing it with the participants (Herr and Anderson 2005). Building trust is a critical part of action research and acknowledging dilemmas is central to building trust.

Coghlan and Shani (2005) highlight a number of areas where ethical and professional dilemmas might arise. Firstly, the action researcher needs to be aware of the political landscape of the organisation and be capable of working the political dynamics within it. As Coghlan and Shani (2005) point out political forces can block change but they can also be used as a means of change if the action researcher is capable of being a 'political entrepreneur' (Buchanan and Badham, 1999) with the self-awareness and reflective ability to deploy appropriate strategies within a particular context. Herr and Anderson (2005) argue that action researchers have a special need to be aware of the effects of



politics given its action orientation and participatory nature (p.64). They consider political dilemmas under 4 headings:

1. The micro-politics of the organisation which represents the behind the scenes activities and struggles over power, position and preferred actions that often never make it to the formal agendas within the organisation. The dilemma of micro-politics is that the actions of the researcher can often have unintended consequences that impact on the research or research design because the political nuances of the organisation are hard to uncover. The researcher may find that their actions offend or alienate and that resistance, openly or tacitly, emerges as a consequence.
2. Action research processes help redefine professionalism and present collaborating stakeholders with new definitions of research and practice that often engages the self in new ways. This brings a political tension between old and new ways and provides potential for conflict as people try and transcend existing defined roles and gain more democratic control over their jobs. This is particularly important in disciplines such as nursing where roles are becoming more controlled and assessed. Action research may provide a promise of emancipation that is difficult to deliver in practice. A clear dilemma for the action researcher is ensuring that the expected outcome for participants is not over-promised.
3. Knowledge is itself political. Central to creating knowledge is the question of what knowledge and who sets the agenda in terms of creating knowledge. The action researcher needs to be aware that the very purpose of pursuing 'thought-trails' (Bartunek and Louis, 1996) is of itself a

political act that gives priority to a particular agenda, intentionally or otherwise.

4. Finally, all local settings are embedded within larger socio-political forces. These forces bring pressures to bear both on the researcher and the practitioner. Indeed, the pressures on the researcher, in terms of publication, peer review and the macro-forces of academia in general should not be forgotten.

Stringer (2007) advise the action researcher to be aware that their presence might result in them 'invading territories' and that they should position themselves so that they do not threaten the social space of others (p.49). He sees awareness of the political networks as a critical action research skill.

Coghlan and Shani (2005) also highlight a number of ethical dilemmas that should be considered. The action researcher faces significant potential for ethical dilemmas to emerge in their work given the participative, democratic and emergent nature of their research agenda. Ethical issues can be as simple as difficulties in maintaining confidentiality and anonymity for participants and co-researchers. A particular issue arises where, as in the hospital study, the case involves working with a limited number of people or indeed an individual. In such case the reporting of reflections provides no anonymity. This problem is further highlighted where a strong trust exists between the participants and the boundaries between personal support and reportable professional reflection become blurred. This issue can however be dealt with through working closely with the co-researchers on writing accounts of the activities. It is important that research design provides for continual feedback from co-researchers. This will

ensure that they have the opportunity to identify and amend any issues with which they are uncomfortable.

This section has highlighted that the role of the action researcher is complex and potentially rife with dilemmas. The researcher needs to tackle these issues up-front by codifying roles and responsibilities formally with the research site and by creating an appropriate working environment built on trust and openness so that emerging issues can be discussed and resolved. It is also important that the action researcher is attuned to and aware of political and ethical dimensions of the project. By continually testing assumptions, by writing accounts of events and sharing them with participants, the action researcher can be better placed to fulfill their role of helping the client to develop appropriate solutions.

### **3.9 The Nature of Theory**

At the meta-level AR approaches can develop theory and the main outcome of this work will be the development of theory on boundaries: what they are, how they function during a merger and how they can be managed to better improve potential integration outcomes. It is therefore important to codify what is meant by theory, how it is built and how it should be assessed. This section will address the concepts of theory and theory building and locate the work by exploring the assumptions that underpin an organisation development approach.

Organisation development as a field has long argued that good theory needs to be useful and that it should be considered in terms of practical value (Kaplan, 1964;



Swanson, 1997, 1999; Van de Ven, 1989). Theory is all around us, it guides our everyday action, implicitly and explicitly. We theorise when we draw links between everyday actions and their expected outcomes. We believe that by doing certain things certain outcomes will flow. Lynham (2002) for instance has argued that the purpose of good theory is to describe and explain how things actually work and, in so doing, to help us improve our actions in this world. She draws heavily on the organisation development principle that research needs to address real organisational problems by being relevant to users of research. Fals Borda (2006) advocates the development of theory through direct action, suggesting that the main criterion for research should be to obtain knowledge for what we judge to be worthy causes (p.29). They quote Bacon's (1607) booklet on 'Thoughts and Conclusions' as resolving the tensions created in giving primacy to practice. Bacon wrote:

*'In natural philosophy, practical results are not only a way to improve conditions but also a guarantee for truth ... Science must be recognised by its works (like faith in religion). Truth is revealed and established more through the testimony of actions than through logic or even observation.'*

Action researchers generally take a less dramatic position but recognise the need to create theory that is grounded in practice and that relates the world of academic discourse to the discourse of practice. This view is not however without its critics. Habermas (1984) saw theory and practice as different and separate activities, distinguishing three discourses, theory, practice and a discourse that mediates theory and practice and links them. Habermas (1973) rejects action research as involvement in practice, which prevents the researcher

engaging in the discourse of theorising. Similarly, the foundations of many positivistic paradigms emphasise the separation of researcher and object and suggest that theory is separate from practice and can only be created through their separation. Action research and organisation development reject this position for a number of reasons. Firstly, as indicated earlier, the complexity of organisational life does not easily relate to the physical sciences, which are more capable of reduction into component parts. OD recognises the need to build more complex relationships into their theories. This does not necessarily mean that they reject the values of science; indeed action researchers argue that rigour is critical in conducting action research. For instance Reason and Bradley (2006) argue that action research is closer to the real paradigm of science than more traditional models. Secondly, action research paradigms have developed new techniques for the development of bridges between theory and practice that allow for more sophistication, quality and transparency in their outputs. For instance, Gustavsen (2006) sees democratic dialogue and relational networks as solutions to bringing the gap between theory and practice. Finally, some action researchers (see section 3.7.1 below) critique the assumptions of knowledge that underpin an objectivist view of research and which acts to separate theory and practice arguing that knowledge is situation-specific.

### *3.9.1 Theory and the Complexity of Organisational Life: Seeing from the Inside*

Checkland (1999) has argued that problems arise when the methods developed for investigating the natural world which exists outside ourselves are applied to the social phenomena of which we are a part ...*[as] the phenomenon involved are ones with dense connections between many different aspects making it*



*difficult to achieve the reduction required for a meaningful controlled experiment.* (p. 67/8). This ‘messy’ nature of the social science creates problems for the application of a positivist paradigm. Firstly, Checkland (1999) argues that any generalizations will have to be imprecise compared with natural sciences. There are many divergent viewpoints which are always ‘confusingly available’ in social sciences. Social systems are open systems subject to many interpretations and entirely unlike more predictable natural systems. Secondly, he argues that the very component of social phenomenon, the human being, creates unique problems and “even if we depersonalize him as an ‘actor’ in a ‘role’ he will be an active participant in the phenomena investigated, attributing meanings and modifying the situation in a potentially unique way.” Finally, he argues that prediction in social systems is problematic because social systems consist of intended and unintended outcomes. Moreover social systems have the capacity to respond to prediction and change and alter in response to it.

Bartunek (1983) has suggested that action researchers by being ‘in but not of’ the researched organisation can gain more valuable information than external researchers. The sharing of perspectives and the challenging of assumptions creates an exchange that provides a marginal stance (Bartunek and Louis 1996). The concept of marginality stems from an idea of Veblen and relates to the concept *of being neither altogether inside or altogether outside the system [which] informs the intelligence and gives the marginal man [sic] the third eye that penetrates the culture as no insider could* (cited in Handy, 1989. p. ix). As an outsider the researcher is capable of dispassionate observation and as an insider they have the capacity to engage in collaborative discourses that question



those observations through the eyes of the researched. In this way the third eye enriches understanding.

Viewing change from the inside provides additional insights within a research design by providing the researcher to challenge assumptions and build understanding from a variety of perspectives. This is particularly important when the aim of the research is to build theory in emerging disciplines or in complex areas of study.

### 3.9.2 *The Process of Theory Building*

According to Lynham (2002) theory building is “*the purposeful process or recurring cycle by which coherent descriptions, explanations, and representations of observed or experienced phenomena are generated, verified, and refined*” (p. 161). Theory building is an important part of inquiry and critical in developing an understanding of the world in which we live. Torraco (1997) highlighted nine prominent roles served by theory. He suggests theory is a means:

1. by which new research data can be interpreted and coded for future use,
2. for responding to new problems that have no previously identified solutions strategy;
3. for identifying and defining applied problems;
4. for prescribing or evaluating solutions to applied problems;
5. of telling ‘us that certain facts among the accumulated knowledge are important and others are not;’
6. of giving old data new interpretations and new meaning;

7. by which to identify ‘important new issues and prescribe the most critical research questions that need to be answered to maximise understanding of the issue;
8. of providing ‘members of a professional discipline with a common language and a frame of reference for defining boundaries of their profession,’ and
9. to guide and inform research so that it can, in turn, guide development efforts and improve professional practice.

How theory is built depends on the epistemological assumptions that are made.

To understand how we build knowledge into a theory we need to define what knowledge is. Objectivist realities emphasize theory building through the systematic recording of phenomena and the uncovering of their recurring properties through observation with the purpose of predicting behaviour and identifying generalisable laws. Building from the natural sciences this theory building method is based upon the creation of hypothesis which can be confirmed or falsified through observation. For example Dubin (1976, 1978) developed a two-part (eight-step) theory building model that starts with defining the conceptual framework and progresses to empirical testing.

Subjectivist paradigms, in contrast, deny the existence of one objective reality and instead argue that all knowledge is situational. Turnbull (2002) notes that social constructionists interpret a social world where no absolute truth is deemed to exist. Theory consists of plausible relationships proposed among concepts and sets of concepts (Strauss and Corbin, 1998, p. 168). and “that science is a

process of inventing descriptions of phenomena” (Reynolds, 1971, p. 145).

Central to theory building in constructionist research is understanding the role of values. Objectivists, in assuming the world exists outside of cognition, strive for value-neutral research. The researcher can detach him- or herself from the phenomenon removing all influences of their own values. If the world is socially constructed, however, the world cannot be separated from its interpretation and accordingly cannot escape from its inherent value systems. In this respect all research is value laden. Interpretative research addresses the value laden nature of research by explicitly acknowledging the values inherent in the research process and by making them explicit. In this paradigm it is not possible to seek generalisable laws but rather the purpose of theory is to understand phenomena from the perspective of the ‘lived experience’ of the individual and extrapolating these insights to seek transferability of ideas toward a redefinition of existing theories (Turnbull 2002). There are a number of frameworks for the development of theory within a subjectivist paradigm (e.g. Lynham, 2002; Janesick, 1998).

Lynham (2002) developed a process for applied theory building. Drawing on the need for theory to have practical relevance in the our world, she argues that it is important that we view applied theory-building research as a necessary and helpful form of scholarly inquiry in developing and expanding our understanding of and ability to explain, anticipate, and act on related phenomena, issues, and problems. Applied theory involves the theorist engaging both the theoretical and the practical so that the ‘knowledge of and the knowledge about the phenomenon central to the theory are brought together through the theory building process’ (Lynham 2002). Rigour in applied theory building can be ensured by the



continuous iterative conversation between knowledge of the phenomenon and experience of the phenomenon. Lynham conceptualizes the research method of applied theory building as a system of five recursive steps:

1. A conceptual development phase that outlines an initial understanding of the problem from current available frameworks. This stage should identify the key elements of the theory, an understanding of their interdependence and the general conditions under which the theory might hold true. The approach to this stage will depend on the epistemological assumptions embedded in the research question. Objectivist research will commence with a theoretical inquiry examining the field of literature (Dubin 1976, 1978) while subjective methodologies may commence exploring the phenomenon and drawing theoretical insights from the phenomenon to inform conceptual development (Glaser and Strauss, 1967; Eistenhardt, 1989a, b).
2. The operationalization phase links the theoretical conceptualisation to practice to confirm or test the theory in real world practice. This phase of theory building is concerned with translating the theoretical concepts into a set of knowledge claims (Cohen, 1991) so that an appropriate inquiry method can be used to validate or build trust in the knowledge claims.
3. The confirmation or disconfirmation phase involves the planning, design and implementation of an appropriate research agenda to inquire into the theory development.
4. The application of the theory to the problem or phenomenon being studied is a critical element of applied theory building. It further enhances understanding of the theory by allowing experience and learning from

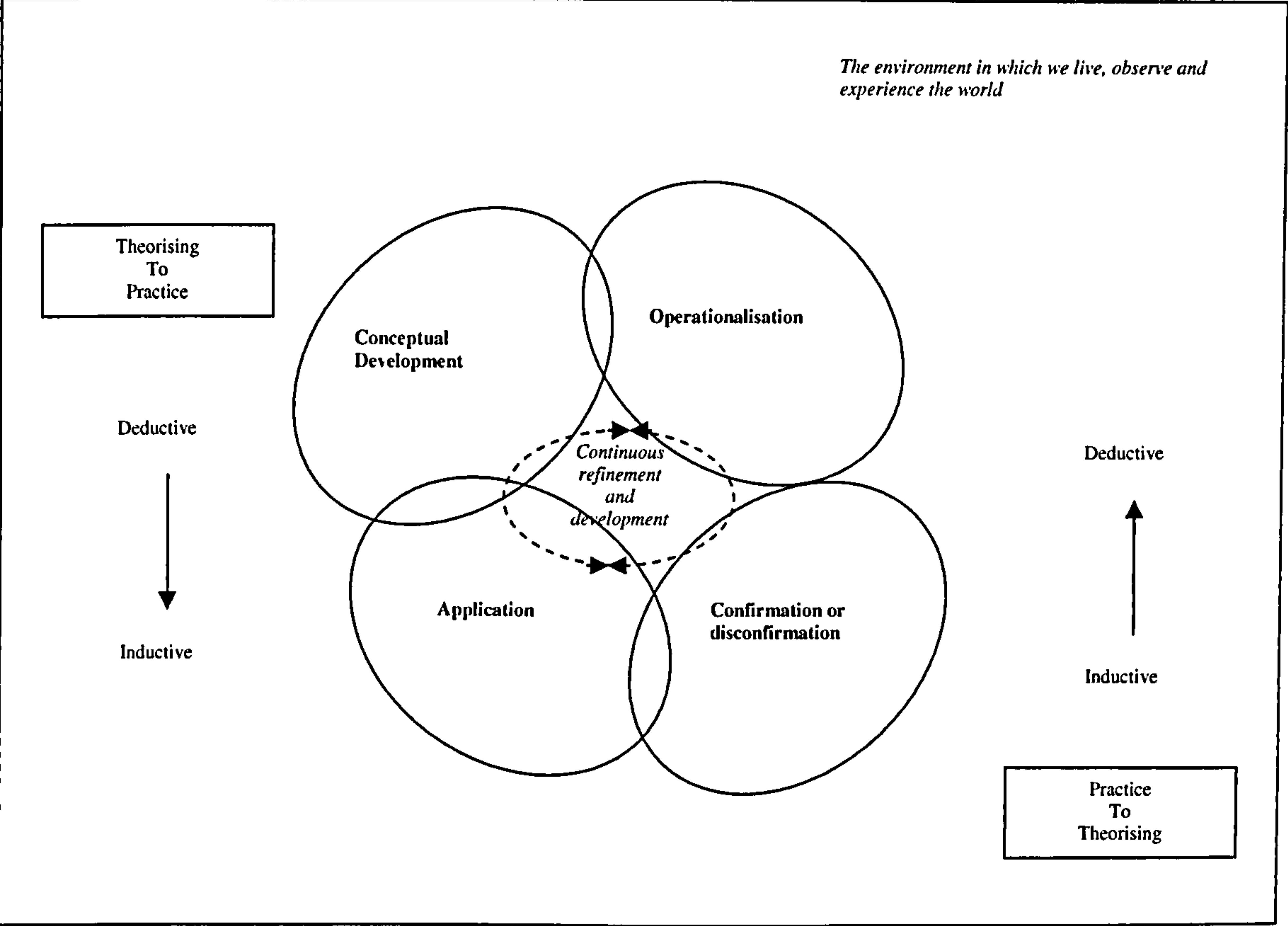
real-world application and outcomes to inform and deepen the theory.

Inquiry into theory through practice enhances judgements about usefulness and relevance as well as facilitating the study of complexity in the theory.

5. The continuous refinement and development (of the theory) is necessary as theory is always an understanding for a given context. It is therefore important that theory is seen as requiring continuous attention to its trustworthiness. This phase requires continuous shifts between the theory as constructed and the application as outcomes to evaluate the relevance and appropriateness of the theory. It is important that theory is kept current.

Lynham represents the relationships between the five cycles and processes of theorizing to practice and practice to theorising as per figure 3.2.

Figure 3.2: The general method of theory building research in applied disciplines



Source: Lynham (2002)

It can be seen from this discussion that theory building is a cyclical process of reflection between theory and practice where knowledge emerges from the ongoing testing of knowledge claims. There are two distinct directions in this process: the movement from knowledge claims to application and the movement from data to knowledge claims. Data can be collected either through practice (i.e. the experience of the application of knowledge) or through the observation of practice (testing knowledge claims). In this way theory can emerge from three sources:

1. Theory developed from theoretical insights (conceptualization and operationalisation);
2. Theory developed from the fieldwork (confirmation or disconfirmation);



3. Theory developed from the practice of applying theory in real world problem solving (application).

This theory building method informs the design of the research work and the structure of the thesis follows the three sources from which applied theory building can emerge: the literature, the development of the theory in the field (the financial study) and the application of theory in practice (the hospital study).

### **3.10 Ensuring Quality in Theory Development**

A crucial part of the research design is ensuring quality in all parts of the research process from literature reviews to dissemination of results. Coghlan and Pedler (2006) have addressed the quality of action learning thesis (which has resonance with AR) arguing that a good thesis should incorporate four elements: the work and the organization that was engaged, the action learning set and what was learned by them, the information and information that was useful in developing thinking and finally the personal and professional learning that has occurred. Reason and Bradbury (2006) argue that the key element in ensuring quality in research is making explicit at all stages in the process the choices that are being made. They argue

*..... that a key dimension of quality is to be aware of the choices, and to make those choices clear, transparent, articulate, to yourselves, to your inquiry partners, and, when you start writing and presenting, to the wider world. This is akin to the 'crafting' of research that Kvale (1995) advocates, or following Lather, away from validity as policing toward incitement to dialogue.' (p.xxiii)*

Earlier, table 3.1 contrasts the quality measures appropriate to objective-positivist research, those of reliability, generalisability and validity to the notion of ‘trustworthiness’ for interpretative work. Trustworthy requires the demonstration that the researcher’s interpretation of the data are credible or ‘ring true’ to those who provide the data (Lincoln and Guba 2000). Herr and Anderson (2005) argue however that trustworthy is not sufficient. They argue that when the researcher is detached from the research phenomenon and they act within or to change a setting through their presence then they ‘contaminate’ the setting (p.50). Where the research role is one of ‘insider,’ as occurs in this work, additional quality criteria should be applied. They develop five criteria for ensuring quality:

1. Outcome validity,
2. Process validity,
3. Democratic validity,
4. Catalytic validity,
5. Dialogic validity.

### *3.10.1 Outcome Validity*

Outcome validity is the extent to which the actions engaged lead to the resolution of the phenomenon under study. Herr and Anderson develop this notion from the concept of ‘workability’ developed by Greenwood and Levin (1998) and link it to similar concepts developed by Brooks and Watkins (1994) and Jacobson (1998). The cornerstone of outcome validity is the focus on action and its successful impacts on organisational processes. As Herr and Anderson (2005) point out, a successful outcome is itself a subjective term definable only in terms

of success for whom (this also links with the democratic validity measure). In this respect success may not be the resolution of a problem but also the redefining or reframing of the existing problem in light of a reflective process. The key measure remains however that cycles of actions lead to relevant outcomes.

### *3.10.2 Process Validity*

Herr and Anderson (2005) suggest that process validity is the manner in which the research supports the creation of meaningful outcomes that include double or triple-loop learning arising from the cycles of action and reflection. Process validity must also address the issue of what constitutes evidence that supports the interpretations of the participants. In respect of this latter problem, they suggest processes of triangulation or inclusion of multiple perspectives as a means of overcoming simplistic views of the data. Process validity also relates to how the narratives about the study are developed and the need to ensure that these are meaningful accounts.

### *3.10.3 Democratic Validity*

Democratic validity is the extent to which the problem owners are involved in the research activities, in the design, execution and analysis of the research. To ensure democratic validity the researchers should engage all parts of the research process collaboratively and give voice to all participants. Action research in particular has as a foundation the notion of ethical and social justice created through the freeing of individuals to come together collectively to improve outcomes (Reason and Bradury, 2006; Greenwood and Levin, 1998). Several



branches of action research go as far as to suggest that achieving emancipation for or within a group is the quality measure for assessing action research (Zuber-Skerritt and Perry, 2002). Action research within an organisational context however is unlikely to achieve emancipating outcomes but should be expected to impact on the lives of the participants such that they have participated in improving not just organisational outcomes but their knowledge and learning about the organisational as well as the self.

#### *3.10.4 Catalytic Validity*

Herr and Anderson (2005) draws on Lather, (1986, p. 272) to describe catalytic validity as “the degree to which the research process reorients, focuses, and energizes participants toward knowing reality in order to transform it.” The research should deepen understanding of the social reality under study and participants should be moved to some action to change it (or to reaffirm their support of it). The key issue in this respect is to demonstrate the change potential of the action research process and how it has changed individuals throughout the process (not least of all the researcher themselves).

#### *3.10.5 Dialogic Validity*

Peer review is the cornerstone of academic processes. Only by opening your work up to others for inspection and debate can the academic truly evaluate the argument. In action research this is particularly important and a crucial quality measure. The data collected is often less structured, more interpretative and closer to the practitioner than more ‘traditional’ research methodologies. To evaluate action research it is therefore important to engage external debate and



discourse on the ideas and emergent theories as much as possible. Several tools exist to achieve this including collaborative inquiry (Torbert, 1981; Carr and Kemmis, 1986) participating in critical and reflective dialogue with other action researchers (Martin, 1987) or working with a critical friend who is familiar with the setting and can serve as devil’s advocate for alternative explanations of research data (Herr and Anderson 2005).

Herr and Anderson (2005; p.54) relate these five quality criteria to the goals of action research which they define as a) the generation of new knowledge, b) the achievement of action-oriented outcomes, c) the education of both researcher and participants, d) results that are relevant to the local setting, and e) a sound and appropriate research methodology. Table 3.3 matches the individual goal to the quality criteria that can be used to judge its achievement.

Table 3.3: Anderson and Herr’s goals of action research and validity criteria

Goals of Action Research	Quality/Validity Criteria
The generation of new knowledge	Dialogic and process validity
The achievement of action-oriented outcomes	Outcome validity
The education of both researcher and participants	Catalytic validity
Results that are relevant to the local setting	Democratic validity
A sound and appropriate research methodology	Process validity

These measures of quality will be addressed as part of the assessment of the quality of the data analysis and the overall quality of the work in the appropriate data-analysis chapters.



### 3.11 Conclusion

This chapter has laid-out the principles of organisation development that guide the work of the thesis and inform the method decisions. The chapter argues that it is importance to build theory *in* practice to ensure the relevance of outputs and to improve understanding by co-creating knowledge with the users of that knowledge. A ‘marginal stance’ (Bartunek, 2008), researching at the intersection of theory and practice with insiders and outsiders combining, provides additional insights to explain the world from multiple perspectives and enhance the wider understanding of phenomenon. Collaborative AR is an effective means of generating deeper explanation of phenomenon and enhancing the quality of the research output.

The chapter also establishes a clear set of criteria by which the thesis engages quality and validity measures to assess the outputs of the research. It argues that ‘trustworthiness’ the traditional measure for qualitative methodologies needs to be expanded for action research methodologies concluding that the framework adopted by Herr and Anderson (2005) which specifies five criteria for assessing validity is appropriate for this research. This framework will be applied in determining method decisions taken (table 4.4) and in the conclusions (table 11.3) to assess the quality of the thesis.

This chapter also addresses the nature of theory and what constitutes good theory development. It is proposed that theory is considered as the plausible relationships among concepts and sets of concepts (Strauss and Corbin, 1998) that allow us to understand lived experience and to transfer ideas into insights



that guide our everyday actions. Drawing on the work of Lynham (2002) theory development is a continuous cycle of refinement and development that moves from theory to practice and from practice to theory in cycles of conceptual development, operationalising, applying and confirming. The three-pillar structure of the thesis reflects this cycle of theorising, building from the literature, from field work and from application in practice.

The next chapter explains how the action research framework will be put into practice and how it guided the decisions taken in respect to the execution of the research.

## 4 Method

### 4.1 Introduction

Operationalising the action orientated approach, this research conducts two major longitudinal studies, a financial services study and a hospital study. The first study builds new theory in the field of boundary management and the second study applies the theory, developed in both the literature review and in the financial study, in action to support a complex M&A integration. This chapter sets out the study selection decisions, the processes by which the data were collected and how the data were analyzed. While action research design can be defined at the initial stages of the research, it is important to realize that some sense of emergent design is always needed. As cycles unfold changes in expectations and through the processes of reflection will create new challenges and opportunities. In this respect the method must:

1. ensure that appropriate choices are made in the selection of collaborative partners and that the ethical and moral dimensions to research and action research, in particular, are attended to effectively;
2. ensure adequate evidence upon which to base cycles of action;
3. ensure that all data is collected systematically and consistent with the objectives of the action cycle being assessed;
4. emphasise reflective practices and inquiry.

This chapter will facilitate an assessment of the quality of the research by making explicit the decisions and assumptions made in the design and execution of the research. To do this the chapter will

1. set out the decision on the choices of organisations selected for study;
2. describe the logic behind conducting the financial services study and outline the process by which the study was conducted;
3. describe the logic behind selecting the hospital study and describe the processes of engagement and the cycles of action and reflection;
4. describe how the research design ensured quality in the collection and analysis of the studies;
5. set out the weaknesses of the method.

#### *4.1.1 Determining Criteria for Selecting Organisations for Study*

A two case strategy was adopted because of the need to develop deep insights into the context and operation of the case studies and because of the need to build theory within a triangulated framework as presented in the methodology section.

Yin (2003a, 2003b.) identified several case selection strategies that can be adopted. He suggests that these relate to single or multiple case designs and the unitary or multiple levels of analysis. Unlike quantitative methodologies the purpose of case studies or action research is not to produce a representative selection of studies but to conduct studies that allow depth of understanding about a phenomenon. Selection was therefore based on the relevance of the study to answering the research question rather than being representative, in some way or other, of a wider population. Two questions that must be addressed in selecting organisations for study is the trade-off between,

1. depth or breadth of study and
2. the number of studies conducted.



The decision to engage depth rather than breadth is based on the discussions in the literature and methodology chapter that indicate that the work must

1. adopt a systems view that considers the dense links between organisational elements;
2. understand the context surrounding the change;
3. have a longitudinal design that captures the change in motion and which allows greater opportunities to reveal the process in action;
4. apply the principles of quality research as indicated in chapter 3.

It is clear from these requirements that depth of description and deep understanding about the operations of the organisation are necessary. The appropriate strategy is therefore for depth of study over larger comparative numbers of studies.

The second choice that had to be made was the number of studies to be selected. The choice of conducting two studies stems from the methodological framework adopted (chapter 3). Theory building processes can consists of three sources, theory building from existing theory, from fieldwork and from practice and these represent the three pillars of the overall thesis design identified in the introduction (table 1.1). The thesis will improve its reliability and the validity of its theory development if multiple sources of theory are used. By triangulating the three strands greater confidence in the conclusions can be achieved. To do this a sequential process of theory building is needed where each step of the study informs the following stage while collectively building a new body of theoretical insights that contributes to an understanding of how boundaries can

be changed in a merger. The first study must translate the boundary understanding developed in theory (Chapter 2) to the M&A context by exploring in the study what boundaries existed and how management interventions impacted on them. The second study must engage the theory in solving a practical problem to develop theory *in* practice and to explore how boundaries operate in practice. This distinction is important as while there is a relationship between the two studies, that relationship is defined by the process of merger integration (and the existence of boundary changes that must be managed), rather than any direct comparability between the two studies. In other words the studies are comparing the process of boundary formation and not other demographic characteristics of the particular organisations. This is an important distinction in case selection in deciding whether the organisation must have similar characteristics (i.e. industry, size etc). Given the emphasis on merger integration (at the intra-organisational inter-group level) as the focal point of the research the importance of similar merger processes, notably that the organisation must have a structurally defined change that involved groups of people coming together to form a combined entity with full procedural, task and human integration, was the overriding criteria for case selection. Selecting two cases also adds value to the study because it provides opportunities to

1. replicate findings across two studies which would strengthen the results and their validity;
2. explore complementarity, the first case being a 'typical case' and the second being unique and an extreme case of potential M&A boundary problems.

It is also worth noting that choices in conducting in-depth studies are not always solely at the discretion of the researcher. Two particularly important points are relevant to the extent of choice that the researcher has in implementing an 'ideal design' when working with case companies. Firstly, the availability of an appropriate case study that tightly fits the criteria for selection may not actually present itself at the appropriate time, or indeed a suitable study may exist but the phenomenon under investigation may occur at a different pace than expected, or indeed not occur, so what commences as a promising study can prove frustrating. Secondly, the availability of a study may not result in the authority being granted by the site to conduct the research, or changes in personnel or responsibility, can result in the warrants issued to the researcher being withdrawn. These are well known research problems in the qualitative domain but are heightened when, as in this case, the study is of a longitudinal nature or is investigating a very specific process. This latter point is very important in the case of this research as it is being conducted on a very specific part of a merger process and is dependent on a strategic objective being present (integrating of staff) as a necessary condition.

#### *4.1.2 Selecting Two Studies*

The two studies conducted involved a financial services merger and a hospital merger. The criteria for the two studies was driven by the need for examples of companies that required high levels of integration post-merger and had potential for boundary issues to emerge within the integration process.

The purpose set for the first case (the second pillar of the research design) was to develop an understanding of boundaries and how they developed and change,



longitudinally, as a merger unfolded. A suitable study was located from a review of national M&A media coverage. The company met the criteria for the study because the merger objectives clearly expressed the need to build a strong combined organisation that built on the best of both combining organisations. In addition, at that time I was lecturing on an executive post-graduate programme and one of the participants was a branch manager in the merging firms.

Discussing the merger with him in terms of the changes occurring and in terms of the culture of the organisation suggested to me that this might be a potential typical case to explore. My informant offered an introduction to the senior manager responsible for the merger integration team and I subsequently contacted him by letter to arrange a meeting. We initially met in July 2001 and agreed to proceed with the research. Corporate and contextual information was collated toward the end of 2001 and the beginning of 2002 with interview data collection occurring from April 2002 to August 2003. Access to this company had not proved as easy as first anticipated and the sponsoring senior executive, while supportive, was difficult to access on a regular basis (due no doubt to the extensive workload and responsibility).

While the analysis of the financial services case was being conducted in the late summer of 2003, the search for an action research study commenced. Once again media reports were studied to locate suitable companies; however, the identification of the study came about during a work meeting. A new research group, the Centre of Management Research in Healthcare, had been established in my academic unit. During a meeting of the group and a senior regional manager within the hospital network the potential need for research and support

for a hospital merger was raised. A unique case existed in South Tipperary where a history of boundary problems around the merger of two hospitals existed. It was suggested that the amalgamation of the services was imminent as the physical infrastructure was now in place but that substantial human integration problems and high levels of resistance still existed. After an introduction from the senior regional manager I contacted the Hospital Manager and met with her to discuss the potential to conduct research on the amalgamation of services. We met in November 2003. Our early discussions revolved around the dual issues of her needs, in practice, of getting the amalgamation to work effectively (and using whatever help was possible to that end) and my needs of conducting theory building around the issue of boundaries in M&A integration. We agreed that we could work together to satisfy these needs and drafted and agreed a memorandum of understanding that set out the terms and obligations of both parties (see appendix 4). This initiated a series of cycles of reflection which are more wholly described in other parts of this methods section and in the case description. The pending merger of the two hospitals, while initially scheduled to take place within a few months was not completed until January 2007, just over three years after my initial introduction to the hospital management team and almost twelve years after the initial ministerial order. The period of the research data collection and reflection therefore commenced in December 2003 and ended in January 2008 (the final reflection meeting with the hospital management team took place 12 months post-merger). While the time-lapses caused significant delay in the completion of the research, they also provided unique opportunities to study the pre-merger phase of the merger process in a level of detail that is traditionally

impossible. In this regard the research offers a unique example of this stage in the merger process.

## **4.2 The Financial Services Study**

The financial study was designed to compare three sets of combining branches, all of which were managed through a central integration unit. Three branches were chosen so that branches at different stages of the merger process could be studied, one branch was merged for some time, one was newly merged and one branch covered a longitudinal study of pre- and post-merger periods. In this way the study allows a longer time line to be considered and comparability along the time line (i.e. were the same problems encountered 6 months post-merger) and to compare individual performance in each branch based on the similarity and dissimilarity of processes.

The three core objectives of the financial study were:

1. To identify the broad categories of boundaries which present the potential to become salient within a merger;
2. To explore how the boundary categories may be managed to reduce the potential for them to create salient differences within the amalgamation;
3. To suggest a model of boundary management that is capable of being applied in an action research mode to manage an actual amalgamation.



There were a number of cycles to the data collection in the financial services study:

1. Building an understanding of the context of the merger;
2. Designing method for studying the branch network to realize research objectives;
3. Analysis and reflection on data.

A benefit of the financial services study was that branches in the network operated with a degree of autonomy and the merging of the branches each represented an individual study of inter-group boundary change. The study was therefore designed to engage three sets of merging branches at different stages of merging (see section 4.2.3) enhancing the capacity to study within and across the three individual mergers and to consider the impact of time and learning on the three branches.

#### *4.2.1 Developing the Boundary Framework*

The objective of the financial services study was to deepen the understanding of boundaries in practice prior to instigating an action research programme. A core ethical imperative within any action research is to ensure that the interventions are based on sound knowledge prior to any actions taking place. The boundary approach to merging units therefore needed some theoretical development before an action research programme could be initiated. Completing the financial services study would

1. provide greater assurances that the boundary approach had value in practice (the ethical imperative) through the identification of various boundary types within the financial services firms;
2. complement and extend the theoretical understanding of boundaries;
3. provide a framework for the action research programme.

#### *4.2.2 The Case Context Data Collection Phase*

The merger was a high-profile merger between two large Irish organisations and as a result substantial press and other media sources were available. The merger itself had been publicly announced and the strategic rationale and aims (including implementation issues) had been put into the public domain. This provided a good source of data to initially evaluate whether the case provided the necessary conditions for this study. The timing of the merger implementation was an important consideration and while the group had commenced the merger process in the central management areas the branch network was still to be merged<sup>5</sup>.

A second part of the data collection on context consisted of two interview meetings with the head of the integration office in October and November 2001. As part of these interviews I spent a full day in the integration office and worked through the merger files that outlined the development of the merger plan and the work-stream model that had been adopted. Of particular note was the data collected to support the analysis and decisions taken. The company had itself conducted substantial research on staff culture and feelings about the merger

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<sup>5</sup> The company was initiating a branch wide audit and evaluation to determine which branches would remain open, be closed or be merged with another branch.

through a number of focus groups<sup>6</sup>. In total the company conducted 10 focus groups, five from each side of the merger and this included a mix of central management and branch staff at a variety of levels in the organisation<sup>7</sup>. The detailed merger plan, the data on the focus groups and other ancillary information, such as newsletters, were provided to me for my own files and for further analysis.

At the final meeting with the Integration Manager in November it was agreed that I would discuss the merger context with a regional manager, identifying a number of retail offices that would satisfy the research design and would be researched through a case interview approach. The regional manager would provide an introduction and facilitate access. It proved difficult to arrange a meeting with the regional manager (who covered a huge territory and was often unsure of what part of the region he would be called to on any day) but a number of phone calls in early 2002 and a number of emails (including an email questionnaire) provided the necessary background I needed and the necessary context for the regional manager to propose some potential retail branches for study.

The merging of the retail branches was scheduled to take place over 12 months (and this had commenced in October 2001) but these mergers varied in size and complexity. Some branches offered limited product ranges or consisted of a

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<sup>6</sup> The term 'focus group' was actually used by the hospital and the thesis uses this term given it was not a part of the actual AR research. It is recognized however that strictly within an AR paradigm any interaction with staff is an intervention.

<sup>7</sup> The data collected through these focus groups were very interesting but as I was not involved in the design, implementation or analysis of the focus groups I could not be sufficiently sure of the reliability and validity of the data to include it as part of my own analysis. In this respect I used the information as context-building and confirmatory only.



small number of staff and were not suitable contexts for the study. We concluded that only branches of a certain scale and size (12 –25 staff) were potential research sites and based on these discussions three branches were chosen. Given the size of the branches interviews with a small number of staff would represent a significant number of informants relative to the overall size of the branch.

#### *4.2.3 Selecting the Branches for Study*

The choice of the branches for study needed to achieve the following conditions:

1. allow for longitudinal study;
2. provide sufficient access for in-depth analysis;
3. provide for interviews with staff from both combining firms and the manager of the combined branch;
4. provide access to sufficient respondents to ensure adequate data collection, notably that a sufficient proportion of the branch staff should be interviewed.

In the end three offices were identified for study. Table 4.1 outlines the logic behind the selection of the branches for study. The logic of this research design included:

1. The capturing of longitudinal data in a branch that had boundary issues emerging and which afforded the opportunity to discuss the merger with the same people both pre and post the merging of the branches (case 2).
2. The collection of data from a branch that had experienced the merger some time previously and was six months past the initial merger integration problems. This allowed for both merger integration issues to



be addressed but also the impacts of the merger on more medium-term performance considered (case 1);

3. The inclusion of a branch that merged toward the end of the merger programme and accordingly could draw on a greater range of experiences from the central merger integration office (case 3);
4. The mix of longitudinal real-time data collection with historical accounts provided capacity to develop greater confidence in the validity of both the longitudinal and historical accounts through the cross-comparative analysis of the data.

Table 4.1: The rationale behind selection of branches for study

Branch	Logic for choosing	Number of interviews conducted	Dates conducted
Case 1	One of the first branches to merge so they had the longest history post-merger. Also one of the most successful in integration terms and often quoted as best practice.	5 interviews all post-merger	April 2002
Case 2	Branches pending the merger – with potential difficulties in the process. Offers longitudinal design and study.	5 interviews pre-merger 3 interviews post-merger (previously interviewed) <sup>8</sup>	April/May 2002 July 2002
Case 3	Late merger allowing adoption of best practice developed over the course of all the branch amalgamations. <sup>9</sup> Purpose to confirm and validate existing data.	3 interviews all post-merger	August 2002

#### 4.2.4 Conducting the Research Interviews

Yin (2003a) suggests that an appropriate framework for conducting interview-based case research is to develop an interview protocol<sup>10</sup>. A protocol is ‘a major way of increasing the reliability of case study research’ (Yin, 2003a; p.67) by

<sup>8</sup> The lower number of interviews in the second part of this data collection resulted from two of the informants not being available for interview at the second stage of data collection. One had left the branch and the other was on long-term sick-leave.

<sup>9</sup> The choice of the third branch changed as the research progressed. The initial choice proved difficult to interview due to unavailability of the manager and during the attempt to arrange a meeting the manager of the branch left to take up employment in another firm.

<sup>10</sup> Copies of the case protocols are included in appendix 2.



structuring both the field procedures and the general format of the case questions. With this in mind a case protocol instrument was developed for the interviews. The protocol addressed the major procedural issues (introductions, recording and confidentiality) that needed to be agreed at the outset of each interview and also created a questioning structure. The question structure followed the literature review on boundaries and aimed to highlight the differences that were emerging between the two firms in physical, behavioral and cognitive terms. Questions were structured to explore the changes that were taking place and by asking the informants to reflect on the similarities and differences that they perceived existed between the combining groups. Slight variations in the interview protocols were needed to distinguish data requirements for the management interviews, for the staff interviews and for the pre and post amalgamation interviews. The structure of the protocol design also facilitated the coding of the data in the analysis stages. All interviewees were asked permission to record the discussion and all agreed to the request<sup>11</sup>. Interviews lasted from about 30 minutes in the case of the shortest to about 1 hour 15 minutes for the longest. The average discussion was about 50 minutes. The interviews were conducted in an open-ended questioning style with the interview protocol used to guide the discussion (and ensure that issues were not omitted). Notes were taken during the meeting to augment the recording and as soon as possible after the event a brief note was written on my initial feelings about the interview. All interview tapes were then professionally transcribed using a transcription agency. The transcription agency held a confidentiality agreement with all their staff and the transcription of the tapes was covered by this agreement.

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<sup>11</sup> The full list of interviews and dates are included in appendix 1.



#### *4.2.5 Data Analysis for the Financial Services Study*

The data was input into Nvivo for analysis. Nvivo is an effective software tool for organizing qualitative data with the capability for dealing with a large body of complex documents, including research interviews, research notes and external documents (Richards, 2002). Nvivo is also an intuitive package that is easily used and learned. It offers the capacity to develop a coding structure as the data is analysed and to form and reform a coding structure as the data analysis unfolds.

The data was initially analysed using a free coding structure with the only structure being the identification of possible boundary differences. Each transcript was reviewed and coded with ideas emerging in an unstructured manner. Once this was completed, all the transcripts codes were reviewed to collate them into groups or to collapse them into a single concept. This process of coding and review continued until there appeared to be no further categories or reduction possible.

To ensure the validity of the coding constructs a description of each code was created as the coding theme emerged. This allowed a coding structure document to be created (see table 4.2) which in turn facilitated a quality check on the coding through the recoding of all the documents using this as a template. The process of recoding provided greater assurances of the validity of the data and all the themes reported coded consistently in the quality check.



Table 4.2: Coding aid for boundary identification (developed in financial study and used in hospital study)

Theme		Definition / Measurement		Key Identifiers in text (references to)	
Description		Sub-theme Description			
Physical Boundaries			Physical entities/objects/artefacts that can be used to distinguish one organisation from another What one organisation can 'own'	Use sub-categories only	
		Job description	Differences in the tasks or terms and conditions of the staff	Terms and conditions of employment Hours of work Physical work completed Surrounding activities such as tea breaks etc	
		Product set	Differences in the products on offer by each firm	Product ranges Services offered 'What we sold'	
		Location	Differences in the physical location and lay-out of the branches	Current or previous building (the branch location) Lay-out or structure of building (space etc) Physical branch environment (quality of buildings etc) Physical contents of the branch (furniture etc)	
		Colleagues	Differences in the people within the branch team and changes therein	Numbers of staff or staff size of branch Entry or exit of staff Knowledge of team members The team as a unit or references to 'The Family' as a unit	
		Owners	Differences in the form of ownership	Head office Being directed by others outside of the branch	
		IT System	Differences in the IT system in the organisation	Banking or mortgage systems Changes to IT systems Software	
Behavioural Boundaries		Leader	The branch manager as a symbol of leadership in each branch	The manager role Responsibilities of manager Support of the manager Directions given by manager Interpretations of the manager as representing one side of the merger Knowledge of the manager	
			Differences in the acts or actions that are expected or acceptable in each organisation.	Use sub-categories only	



	Personal Investment	Different in the expected level of commitment that an individual is willing to give to the organisation (Relationship with self)	Time commitment to work Commitment to the organisation Amount of work done Effort given Personal Attitude Position of work in the life of the informant
	Work Processes	Differences in how the work of the two organisations are performed	Work procedures and routines Focus on aspect of work (selling v service) Status or importance of tasks Speed of response to customers Requirements of doing a good job for any given task
	Team Behaviour	Differences in the norms of behaviour and relationships that exist within the branch team (Relationship to colleagues)	Team interactions i.e. flexibility, support etc Participation in the team Personalities Nature of relationship between team members i.e. openness, friendliness etc
	Customer Service	Differences in the way in which staff interacted with the customer (relationship to customer)	Interaction with customers Relationships with customers Speed of response to customer Selling to customer v servicing customer Queue management
Cognitive Boundaries		Differences in the way the staff think about the purpose and activities of the organisations	Use sub-categories only
	Belonging	Sense of identity and belonging to the original group/branch or organisation and the associated definition of what that identity means	Sense of membership of a group and accepting group value set Categorisation of the groups along identity grounds (ie family, underdog, status locally etc) Sense of achievement Personalisation of previous work society Sense of personal fit/misfit with group (old or new) Changes in the identity from organisation of heritage
	Work Assumptions	The underlying assumptions about how the work in the organisation should be order and completed Differences in the general values and understandings that each organisation applies to their work usually expressed as a value of importance of an activity or action	Definition of Customer service Logic of why work should be done in a particular way Statements of value or belief about the organisation Definition of bank v building society activities Relative value of tasks and activities and why there are important Key tasks/achievements of organisation



#### *4.2.6 Assessing Quality of the Research Findings in the Financial Study*

The criteria for evaluating the quality of the research findings established earlier were addressed in this part of the research design. The key issues in this initial study that needed to be addressed included

1. ensuring rigour in the systematic collection of data and the analysis of that data;
2. exposing the data and the analysis to critical peer review and/or the review of the informants or participants.

The financial services studied delivered on these quality measures by

1. developing a formal protocol for conducting the research;
2. developing a structured mode of data analysis and theory development;
3. showing a draft of the analysis to the Integration Manager in the case company for his comment and review, no comments were received;
4. discussing the general themes with an informant in the company;
5. publishing the findings of the study at academic conferences (O'Byrne and Angwin 2003).

### **4.3 The Hospital Study**

The hospital study explored the merging of two hospitals, one in Clonmel (a medical facility) and one in Cashel (a surgical facility) into a combined full service hospital. The new hospital is housed on the site of the pre-existing Clonmel operation and accordingly Cashel staff was being transferred from their existing facility.

The objective of the hospital study was to explore how boundaries could be changed in practice to improve the potential for success post-merger. This is the overall research question. To achieve this overall objective a number of sub-objectives were established based on the need to make meaningful contribution to the hospital, to meet the ethical demands of a action research and the need to build from the theory developed in the earlier sections of the work. These objectives were discussed with the hospital management team and agreed as follows:

1. to strengthen the theoretical understanding of boundaries in a merger by developing the theory established in the financial services study;
2. to explore longitudinally, and in practice, how the boundaries of the hospital units shift and alter throughout the merger process;
3. to assist the hospital management design and implement change interventions to support the integration of the two hospitals;
4. to assist hospital management to avoid a ‘hospital within a hospital’ emerging post amalgamation;
5. to build a democratic action research process that assists the hospital management (and where possible staff) create a cycle of reflection that informs practice in building a unified organisation post-merger;
6. to create a sustainable, successful working organisation built on the foundation of the learning achieved in the study.

Action research processes are characterized by a number of factors as outlined in section 3.6. The implications of these for conducting this research are that

1. research is conducted *in* action rather than *on* action;

2. the research process is a collaborative process between participants and the researcher;
3. cycles of planned actions, evaluations, reflections and adjustments form the basis for theory building.

#### *4.3.1 Agreeing the Terms of Engagement*

The initial stage in any collaborative or action-orientated methodology is to clearly establish the roles and responsibilities of the participants and their expectations of warrants afforded to each member of the group. My initial discussions and meetings with the Hospital Manager concentrated on the terms of the engagement and agreeing the roles and responsibilities of each party, particularly in the context of the two issues.

Firstly, the perceived need in the hospital was for ‘consultant’ focused assistance, which would guide the hospital through the integration process. I was conscious that I was coming to the discussion as an academic who had worked in the change field and who held a position consonant with a consultant role<sup>12</sup>. My need was to develop a participative and sustainable process that helped management (in the traditions of action research) to foster double-loop learning coupled with the need to build knowledge (in action) about the boundary changes that take place as part of the merger.

Secondly, there was a serious concern in my own mind about who should be the participants in the process. Action research emphasises the democratic

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<sup>12</sup> At the commencement of this process I was a senior lecturer in my academic institution and head of an academic department



imperative in research and the need for research to liberate and emancipate groups as part of the process. Many action researchers suggest that the only way to conduct projects is to involve *all* the participants involved with the problem. This is the difference between research *with* people and research *on* people. This presented a significant challenge within this study and required an initial clarification of what participation means within the context of the hospital study. The changes arising from the hospital merger affected all the staff in both hospitals. The management structure, however, was designed in a hierarchical manner with strong union-management roles and clear demarcations.

These issues were resolved and the terms were laid out in a formal letter, exchanged between the Hospital Manager and myself (appendix 4) detailing the conditions we agreed to follow in the research process. Role issues were resolved through the explicit recognition of my purpose of completing a doctoral qualification. This was evidenced by the refusal in one instance of a group of staff to meet with me, as part of a hospital-run activity, because they 'did not wish to be quoted in a PhD'. Additionally, however, I was conscious of my interactions in meetings and discussions and the need to position myself as an inquirer and as a supporter rather than as a 'knower.' This became a matter of practice throughout the years working with the hospital, and particularly with my interactions with the management team. The main technique I adopted in resolving this issue was 'to inquire.' At decision points I would always ask for people's objectives, what they wanted to achieve and why they wanted to do it in a certain way. This stimulated debate and sharing of ideas.

The second issue, achieving a wide participation base, was more problematic. Early discussions with the Hospital Manager, however, demonstrated that the culture of the hospital supported democratic structures and opportunities for all staff to contribute to processes. There was a clear commitment to learning and staff development and reflection. Translating this commitment into practice given the constraints of a national structure of hospital and health provision is an ongoing challenge for the hospital management. In respect of the merger, a working group structure was established. An executive committee consisting of staff at both management and staff levels led the process and was supported by an operational group (those who would be dealing in practice with the changes) and a number of partnership<sup>13</sup> groups (charged with the design and development of new processes by the staff involved in those processes). Substantial cross-fertilisation of membership in each group and a formal reporting structure ensured connectivity and coordination between groups. In this respect an emancipating structure was developed (although it does not necessarily support double learning at all levels) where all members of the hospital communities had the opportunity to participate. An open invitation to participate was issued to all staff. My working relationship was directly associated with the Hospital Manager, the Integration Manager and later with the operations group team leader. These people were the drivers of the process and constituted the main management and action research group for the study.

The importance of reflection and learning was further demonstrated by the insistence of the Hospital Manager that I had a formal relationship with the

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<sup>13</sup> Partnership groups arose out of a national programme of union-management cooperation in the public and private sector aimed at improving dialogue and cooperative decision making. (www.ncpp.ie)



hospital and that the hospital benefit directly from the research and from the ‘external view’ and knowledge of change management that I brought to the table. In that respect I was invited to become an advisory member of the executive committee and to input into the ongoing management of the amalgamation. How I would input into this group was discussed with the Hospital Manager and it was agreed that I would:

1. act as a facilitator to help focus discussions and assist the team in coming to its own decisions;
2. raise issues of concern around people and change management within the team, specifically in relation to M&A practice and within the context of the boundary model;
3. collect and disseminate data to assist the cycles of reflection and analysis;
4. work with the integration management (the Hospital Manager and the Integration Manager) to develop and implement hospital-wide communication and feedback processes in support of the amalgamation.

#### *4.3.2 Agreeing a Boundary Approach*

Initial discussions with the Hospital Manager assessed whether the boundary approach was relevant to the hospital and could be of assistance in conceiving and managing the integration process. The financial services study provided a useful output in directing and informing these discussions. We had discussed the boundary model in some detail in the early meetings and decided that I would collect background information on the hospital to inform myself about the issues that might arise and about the operation and management of the hospital. Over a period that spanned seven months I met with the assistant manager on a number

of occasions, the director of nursing and the Integration Manager (see full schedule of meetings in appendix 3). During this time little progress had been made in the amalgamation as HR and physical development issues were being addressed. In the summer of 2004 the integration executive management team first met. This led me to codify the boundary approach with the Hospital Manager. After initial discussions I drafted a paper on the theory based on the financial services study<sup>14</sup> and met with the manager in the Health Services Executive Headquarters in October 2004. At this meeting we agreed that the theory had insights into the hospital study and that the major issues existing at that time fitted the theory and experience of the financial studies case. We therefore agreed that the actions should be discussed at the next executive meeting and that we should agree an implementation schedule arising from that. We also discussed the notion of bringing the boundary model to the consultant group as a means of opening dialogue on the potential differences between the two hospital sites but this was not achieved due to the hesitation of the consultant group to engage directly with me.

#### *4.3.3 Cycles of Action and Reflection*

The hallmark of action-orientated research methodologies is codified cycles of action, analysis and reflection which in turn lead on to additional cycles. The timing of cycles depends on the objectives of the interventions and the time it takes to implement agreed actions and to evaluate outcomes against the objectives set. The number of cycles within a particular project will depend on the number of iterations that the team must go through to achieve the overall

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<sup>14</sup> This was the basis of a subsequent book chapter (O'Byrne 2007).



project objectives. For instance, the project might be delivered in one cycle when the interventions designed deliver precisely on the objectives, but more often team reflection will determine that outcomes achieved are not fully as anticipated or new issues might arise. These will result in an additional cycle of action and reflection. In this way the cycles of action and reflection are not definable at the outset either in times of cycle duration or in terms of the number of cycles. Four cycles of actions and reflections were engaged within the hospital study. These cycles are detailed in the case description (Chapter 7) and Table 7.1 sets out the goals, objectives and actions of each cycle. In relation to the methodology and method of the thesis it is however important to outline the method decisions taken within each cycle and explain the data collection processes within each cycle.

#### **4.3.3.1 *Cycle 1***

The first cycle of reflection and action commenced after the initial meeting with the hospital management team in November 2003 and continued up to March 2005, when the first formal feedback from staff occurred. This cycle was the longest cycle, running for 16 months. It had a number of different sub-stages including an initial diagnosing of the problem and the evaluation of the boundary framework as a means of addressing the amalgamation issues. We decided at the outset that a formal questionnaire would be used at an appropriate juncture to assess the outcome of the cycle.

In late 2003 and early 2004, the amalgamation process was focused on the physical development of the site and the concomitant location issues. The need to

address the human aspect of integration was only beginning to surface in the executive team's mind (although the Hospital Manager was clearly concerned about this issue from an earlier stage). The initial research objective was to collect contextual data and open discussions that helped the management team define the problem in a way that allowed them develop an action plan. The initial data collection focused on assessing the climate for change in the hospital. A number of data sources were used for this assessment.

1. Discussions with the Hospital Manager;
2. Discussions with the Integration Manager;
3. Discussions with the Directors of Nursing in both hospitals;
4. Discussions with the Assistant General Manager;
5. Physical tours of facilities and services in both Cashel and Clonmel
6. Review of data collected as part of the management processes (this included a major review conducted by the Integration Manager to assess staff perceptions through one to one interviews with staff in Cashel;
7. Background reading on the history and development of the hospital (Lonergan, 2000).

The data collection led to a cycle of actions, based on the boundary model, aimed at preventing physical, behavioural, or cognitive boundaries becoming problematic at the amalgamation date. The detail of the interventions made is outlined in the case history and description in the following chapter. The overall thrust of the actions supported team building based on awareness of each other's differences and similarities and the creation of as many opportunities as possible to maximize the interaction between groups through the design of post-



amalgamation work practices. Key process outcome we were looking to achieve were to

1. challenge the existing mindsets that momentum for the change could not be created and
2. build a belief that the amalgamation would indeed occur (and in a participative manner).

The partnership structure provided ample capacity to foster interaction and build appropriately participative decision-making. This cycle ended both by design and through unanticipated events. By early 2005 discussions at the executive amalgamation team and between myself, the Hospital Manager and the Integration Manager led us to believe that real progress was being made and that there then existed a 'real sense that the amalgamation was going to happen.'<sup>15</sup> This led to a decision to evaluate what we had achieved and to assess our perceptions more formally. A questionnaire to all staff was applied in March 2005 (the quality assurance process for the questionnaire are set out in section 4.3.4.2) and this was expected to lead to a further cycle of actions and reflections based on building a common strategic vision and value set for the future. In April 2005, a group of staff in Cashel, through their staff union, the Irish Nurses Organisation (INO), issued a notice to management withdrawing from any further discussions on the amalgamation pending a resolution of a number of outstanding industrial relations issues in Cashel. This effectively put many of the intervention actions on hold and reduced the capacity to plan for the amalgamation. Ironically, the issues at the heart of the debate were outside the

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<sup>15</sup> Notes on meeting with hospital manager and Integration Manager 12<sup>th</sup> Jan 2006

control of the hospital management and could be resolved only through the industrial relations machinery of the State and the agreement of the national-level management within the Irish health services executive.

#### **4.3.3.2 *Cycle 2***

The second cycle of actions and reflections built on the first cycle and on the outcomes of the data collected at the end of the first cycle. This cycle did not transition smoothly from the first cycle. Extensive reflections after the abrupt end of cycle 1 led the Hospital Manager to the belief that we had misconceived the boundaries between the Clonmel and Cashel sites. The Cashel site consisted of at least two separate groups, those that would remain in Cashel and those that would transfer to Clonmel on the amalgamation date. The withdrawal of the Irish Nursing Organisation (INO) from discussions on the amalgamation prevented further participation by staff and effectively stalled the amalgamation process. But other events, such as a national accreditation process, continued to allow amalgamation-related issues to be addressed (for example building unified patient pathways between both hospitals as an issue of quality rather than an amalgamation need). Given the industrial relations problems, cycle 2 was primarily concerned with sustaining the momentum generated in cycle 1. The case description (Chapter 7) outlines how this was achieved. Cycle 2 ended when the INO withdrew their action and returned to the negotiation table. This cycle therefore had a natural end.



#### **4.3.3.3 Cycle 3**

The third cycle recognized the need to deal with the Cashel staff in a multi-boundary approach and to tackle issues for each group in a more individualized manner while at the same time continuing to drive commonality through interaction within and across the hospitals. Indeed the realisation by the hospital communities that the amalgamation would in fact occur facilitated this approach. This cycle of action and reflection continued to the actual amalgamation on the 12<sup>th</sup> January 2007. To support the research data emerging in this cycle 20 in depth interviews (10 in each hospital) were conducted approximately two months before the merger date to augment the data collected in the executive team and management discussions. The detail of these interviews is provided in 4.3.4.4.

#### **4.3.3.4 Cycle 4**

The final cycles of actions and reflections concerned the post-merger period and the bedding down of the new structures and processes. The merger day, the 12<sup>th</sup> January 2007, was a huge success and went more smoothly than anticipated. The extensive planning and preparation of the executive and operation group returned dividends. Both the executive and the operation teams continued to meet post-merger for a few weeks to ensure that problems were addressed but by early March emerging issues were being dealt with through the standard operating structures of the hospital. Again this cycle was impacted by the action of the INO. In March of 2007, national-level pay discussions between the health sector and nurses broke-down with a resulting work-to-rule on the part of the nurses. Once again nurses could not participate in the management functions of the

hospital.<sup>16</sup> To conclude this cycle a further questionnaire was designed and implemented in May 2007. I also marked the end of the research process<sup>17</sup> with a concluding set of 18 interviews (9 staff from each hospital of origin) and exit discussions with the Hospital Manager and the Integration Manager.

#### *4.3.4 Support Data Collection*

There were a number of strands to the data collection in the hospital study:

1. Records of actions, outcomes and events that occurred during the amalgamation process. These included actual events (such as the amalgamation day or approval of a mission statement) as well as recorded discussions such as minutes of the various meetings I attended;
2. Collection of minutes of meetings conducted by other groups, mostly the operational transfer group;
3. Diary notes from meetings with individuals as part of the design, actions, evaluations and reflections in the action research process. These were usually meetings with either the Hospital Manager or the Integration Manager;
4. Diary notes from the meetings and discussions I took part in during the amalgamation process such as executive team meetings;
5. Direct data collected through questionnaires applied at the end of cycle 2 and cycle 4;
6. Direct data collected in 20 interviews conducted three months pre-amalgamation and 18 interviews conducted three months post amalgamation;

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<sup>16</sup> This actually resulted in the deferral of the accreditation process in the hospital

<sup>17</sup> I am still however working with the hospital on the building of strategic planning processes



7. Exit interviews conducted with the Hospital Manager, the Integration Manager, the director of nursing and the operational transfer team leader.
8. Data collected through the joint reflection processes and through discussions on the papers written throughout the research. These reflections took several manifestations, including discussing and co-authoring papers for academic conferences with the Hospital Manager, presentation of the case at an action research workshop for peer review, and the general testing of assumptions and findings with the Hospital Manager and Integration Manager;
9. Brainstorming<sup>18</sup> sessions held with the hospital and Integration Managers, from time to time, in which discussions on critical problems were held to frame issues, objectives or action steps.

#### ***4.3.4.1 Questionnaire Data Collection***

Two questionnaire data sets were collected in the course of the research to evaluate the end of cycles of action and to assist management in determining outcomes achieved. Questionnaire data were instrumental in the reflection process and in trying to build feedback from staff (as a means of increasing participation). The first questionnaire was applied in March 2006 and the second in May 2007. It is important to explain the purpose of these data collection phases in the context of both their contribution to this research and its contribution to dialogue and evaluation within the hospital management structure.

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<sup>18</sup> This point (and exact term) was added as a result of the final joint reflection process held with the hospital and Integration Manager to reflect on what they found as a very useful part of the research process and though not precisely a data collection tool, it does demonstrate the application of research activity in action.

#### **4.3.4.2 *Cycle 1 Questionnaire***

Reflections with the hospital management in early 2005 led to the first questionnaire (appendix 8) as a means of testing certain assumptions we held about the level of effectiveness of the interventions we had made. We believed, for instance, that the communication process was open and transparent and that staff had received relevant information. We had however no real evidence to support that view. Our discussions led us to test those views and accordingly we agreed to survey all staff on their individual perceptions on what had happened to date. In addition, our perceived successes had led the Hospital Manager to consider the need to build a common vision and mission statement for the new hospital and it was felt that a survey instrument may help us to engage staff in that exercise. These broad objectives were then codified into a number of key aims for the questionnaire as follows:

1. to evaluate the extent to which we had succeeded in meeting the communication needs of the staff;
2. to codify the perceived level of involvement of staff in the amalgamation process and the level of satisfaction with that level of participation;
3. to evaluate the level of identification with the hospital unit of heritage and the level of identification with the new South Tipperary General Hospital;
4. to codify the values that staff in the hospitals hold;
5. to initiate feedback on potential mission statements and to codify a preference set among staff.

Aims 1, 2, and 3 directly relate to the intervention objectives that were set in the beginning of cycle 2 and accordingly are akin to ‘measures’ of success in the



cycle. It is important to note however, that the purpose of the questionnaire was to generate descriptive statistics and measures of individual perceptions to provide insights rather than to determine objective realities. Indeed given the earlier discussion on epistemology and ontology to define a social reality that can be adequately described by preformatted statistical analysis would be to oversimplify the complex social order. Indeed, what became evident was that the same processes had very different perceptual outcomes in different areas of the hospital.

The questionnaire (appendix 9) had seven sections. The questionnaire was designed by the collaborative team, myself, the Hospital Manager and the Integration Manager. It was designed to cover the major areas of research and practice. We set as an objective the gathering of descriptive statistics on

1. perceptions about the merger;
2. the quality of communication processes;
3. the level of identification with the hospitals;
4. the perceived similarity of work and culture across the two hospitals
5. the values that hospital staff espouse as important.

The first section asked around the perception of staff on a wide range of issues from information flows to pace of change. The section incorporated a number of simple statements with which the respondent agreed or disagreed along a seven-point scale<sup>19</sup>. A number of statements were created by myself, the Hospital Manager and the Integration Manager and these were discussed collectively and

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<sup>19</sup> A seven-point scale was selected to provide a wider choice to respondents and to examine strength of opinion more widely.

honed to a final list of 14 questions. Section two continued the theme of effective communication using a bipolar scale to assess the perception of communication quality extracted from the quality of communication questionnaire adopted from Mohr and Spekman (1994) and Mohr and Sohi (1995).<sup>20</sup> Section 3 asked the opinions of respondents on a number of possible mission statements, each respondent being asked to rank them in the order of preference (top five). Again, the mission statements were developed in dialogue with the management. The aim of this question (and section 4) was to commence the hospital strategic development process and to build a mission statement within a participatory process.<sup>21</sup> Similarly section 4 involved the perception of values that are important to the hospital. This question again asked for a top five ranking but also compared the value of the hospital of heritage to the new STGH. The development of this question was based on the work of Enz (1986) and involved translating the method and questionnaire developed by her (for commercial organisations) into an appropriate language for a hospital context. This was again achieved in dialogue with the hospital management team, evaluating each value for possible relevance (i.e. profitability does not apply in centrally funded public sector body) and eliminating or altering as appropriate (i.e. value for money). Two additional values, scientific principles and equity, were also incorporated as it was felt that these are unique and specific to the hospital context. Section 5 was adopted from Doosje et al (1995) and was designed to see the extent of identification with the hospitals of heritage and the new hospital. Section 6 was an extension of section 1, designed to test the specific awareness levels about the

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<sup>20</sup> This arose through a suggestion of an academic colleague as a result of the questionnaire pilot.

<sup>21</sup> The questionnaire data were further expanded by two focus groups and presentations in each hospital of the findings. This mission development process while useful in understanding the context of the study was an ancillary activity in the research design.



activities of the partner hospital as well as the level of contact between the two hospitals. Section 7 offered the opportunity to each respondent to identify in an open-ended structure their concerns about or suggestions for managing the amalgamation. Once drafted the questionnaire was piloted for understanding and clarity by the Integration Manager in the hospital and reviewed by an independent academic. This process resulted in the suggestion of some minor changes and alterations as well as a substantial change to section 3 on communication quality.

The questionnaire was applied in March 2006 and was distributed to all staff in each hospital by inclusion in the pay-slip distribution. A total of 403 questionnaires were sent out, 180 of which were sent to staff in Cashel and the remaining 223 were sent to Clonmel. A number of steps were taken to enhance response rates:

1. All staff was informed about the questionnaire before it was circulated through an article in the monthly newsletter explaining the purpose and process of the questionnaire and urging staff to respond.
2. A cover letter was included with the questionnaire, signed by the Hospital Manager, explaining the purpose of the questionnaire and urging everyone to return it.
3. An incentive was presented to staff to complete, with all returned questionnaires included in a draw for a gift voucher.
4. The Integration Manager visited all wards and areas to urge staff to participate both on the day the questionnaire was circulated and a couple of weeks afterwards.

5. Internal collection boxes were placed in central locations to make it easier to respond.
6. The monthly newsletter reminded staff to complete the questionnaire, if they had not already done so.

The response rates to the questionnaire were low with a 27.4% response rate in Clonmel (61 responses) and only 10% response in Cashel (18 responses).

Furthermore the proportion of nursing staff who responded in Clonmel was substantially lower than their representation in the population of the hospital as a whole. However, it is important to note that the purpose of the questionnaires was to gather descriptive data on perceptions and feelings rather than positing an objective reality. In this respect the data are very useful and indeed perhaps more valuable is the realisation of lower staff numbers than expected participating in the process. To explore non-response causes, discussions were held with the Hospital Manager, the Integration Manager (who subsequently spoke with staff and fed back issues) and with the executive transfer team. A number of reasons emerged for the lower than anticipated responses and these included:

1. the industrial relations position in the Cashel hospital (a directive to staff to withdraw from the amalgamation process) had directly prevented nursing staff participating;
2. staff felt they were too busy to participate;
3. a deliberate attempt not to participate in the hope that holding back would delay progress and defer any amalgamation date<sup>22</sup>;

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<sup>22</sup> This point was made in the final reflection discussion with the Hospital Manager and Integration Manager



4. a general level of apathy toward the amalgamation and possibly a reluctance to 'accept' that it was going to happen or that it might yet be prevented i.e. it wasn't relevant to them.

The questionnaire data was input in to SPSS and analysed for means, standard differentiations and comparative differences between the two hospitals. Further statistical analysis was not deemed appropriate given the descriptive purpose of the questionnaire and the ontological assumption adopted within the research of a constructionist world that is not capable of being objectively measured. To ensure quality of the data and its interpretation the data were reported back to the transfer executive team and then through convocations in both Cashel and Clonmel. In all cases the staff confirmed the credibility of the data and its interpretations. The importance of sharing the data with staff at each hospital is also central to the philosophy of the action research methodology. Data is the means by which staff can themselves understand, shape and change their context. In this respect data must be shared with the community if that community is to be informed and liberated in their decisions.

#### ***4.3.4.3 Cycle 4 Questionnaire***

The second questionnaire (appendix 10) was applied in May 2007 approximately six months post-merger to evaluate whether the overall objective of the integration had been achieved (the success of the merger) and to assess the climate of the hospital (and as an additional objective to support the quality accreditation processes within the hospital). The same process of developing the questionnaire was adopted as for the questionnaire that ended cycle 1. The

Hospital Manager, the Integration Manager and I, met to agree the objectives of the questionnaire, cognizant of the needs of both the research and the practice of management in the hospital. The accreditation process had also created a need for greater feedback and consultation across the hospital and the Hospital Manager was keen to formalize the process by which staff had regular opportunities to express their opinions. The cycles of reflection, planning and acting had achieved strong results in the hospital and the Hospital Manager wanted to maintain this cyclical approach, not least of all because it fitted well with the quality improvement agenda required by the accreditation process. An annual questionnaire was agreed as a means of continuing cycles of reflection (which also represents a double-loop learning outcome). The same question format was adopted as in the cycle 1 questionnaire. An iterative process of developing and discussing statements and their appropriateness resulted in the final draft questionnaire

The objectives of the questionnaire were twofold, to follow on from the 2005 questionnaire and to establish a more regular reporting structure for the perceptions about hospital work climate and improvement cycles. The objectives were therefore:

1. to evaluate the success of the amalgamation of services in line with the objectives established (i.e. avoid a hospital within a hospital);
2. to evaluate the extent to which we had succeeded in meeting the communication needs of the staff;
3. to codify the perceived level of involvement of staff in the amalgamation process and the level of satisfaction with that level of participation;



4. to evaluate the level of identification with the new South Tipperary General Hospital.

In addition the questionnaire would

1. gather perceptions on the level of amalgamation success defined by the perceived level of integration that had been achieved and
2. gather opinions on the state of hospital morale at that point in time as a baseline measure for future questionnaires.<sup>23</sup>

Question 1 was designed to assess the amalgamation outcomes and the effectiveness of the new STGH. The question consisted of a number of simple statements with which the respondent agreed or disagreed along a seven-point scale. Eleven statements were developed that drew on our measures of success as being '*operating as one hospital*' and '*working together as a team*'. In addition respondents were asked directly to agree or disagree with the statements '*the amalgamation of services at South Tipperary General has been successful*' and '*the transfer of services is now complete.*' These two questions were direct measure of perceptions of the levels of success. The question also asked about the contribution of staff to the new hospital and the level of service provision that had been achieved post amalgamation. Question 2 followed directly from the quality of information question on the cycle 1 questionnaire using a bipolar scale to assess the perception of communication quality extracted from the quality of communication questionnaire adopted from Mohr and Spekman (1994) and Mohr and Sohi (1995). Similarly question 3 drew directly from the cycle 1

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<sup>23</sup> This objective related to the on-going hospital management and while informative for this dissertation does not form a part of the research

questionnaire by replicating question 4 on social identity using the scale developed by Doosje et al, (1995). Question 4 assessed the work climate and consisted of eight statements (with which respondents agreed or disagreed on a seven-point scale) on enjoying work, feeling appreciated and the general climate and culture of the hospital.

The cycle 4 questionnaire was substantially shorter than the cycle 1 questionnaire in response to feedback from the cycle 1 questionnaire that suggests the earlier questionnaire was too long. The mission statement questionnaire was omitted as this task had been completed and it was felt that the strength and consistency shown in the values and culture section of the first questionnaire was sufficient to make any additional value questions redundant.

The distribution process for the questionnaires was changed from cycle 1. In cycle 1 the questionnaire was circulated through the pay slips of staff resulting in all direct employees received questionnaires. However, many other bodies, such as the Health Services Executive or other community care organisations, could be employers of staff within the hospital. For cycle 2 the questionnaire drew on the human resource records of the hospital and the hospital population was defined as all individuals for whom an active HR record existed. This also had problems. While we could be sure that every member of the hospital community would be surveyed, the records contained several categories of staff that would be included as active in HR but not be in the hospital, for example staff on maternity, parental leave, long-term sick leave and staff on secondment or leave of absence. The risk from a survey perspective is that the population is overstated



and the response rate understated. The importance of this risk however is mediated, given the objectives of the survey and given that the entire population was to be surveyed. In total 997 questionnaires were circulated (this included questionnaires to a constitute hospital within STGH not directly effected by the merger).

The same activities to increase response rates as in cycle 1 were implemented. Specifically,

1. All staff was informed about the questionnaire before it was circulated through an article in the monthly newsletter explaining the purpose and process of the questionnaire and urging staff to respond.
2. A cover letter was included with the questionnaire, signed by the Hospital Manager, explaining the purpose of the questionnaire and urging everyone to return it.
3. An incentive was presented to staff to complete, notably all returned questionnaires were included in a draw for a gift voucher.
4. The Integration Manager visited all wards and areas to urge staff to participate both on the day the questionnaire was circulated and a couple of weeks afterwards.

The response rate was acceptable at 364 responses (36.5%) with a representation from all main categories of respondents particularly nursing (39.2% of responses), and consultants, (4.5% of responses).

Again as in cycle 1, the questionnaire data was input into SPSS and analysed for means, standard differentiations and comparative differences between the two

hospitals. To ensure quality of the data and its interpretation the data were reported back to the transfer executive team and then to two convocations of staff in Clonmel. In all cases the staff confirmed the credibility of the data and its interpretations, although some were surprised by the positive outlook.

#### ***4.3.4.4 The Interview Data Collection***

Two sequences of data collection of a ‘traditional qualitative method’ were employed around the amalgamation date. The purpose of this data collection was to support the findings by understanding more deeply individuals within each hospital and their perceptions. The decision to implement this phase of data collection focused primarily on the academic research process and the strengthening of the findings rather than assisting the hospital management in the ongoing action research process. The process was designed to replicate the process of the financial services study with two sets of interviews conducted approximately three months pre-amalgamation and three months post-amalgamation. A major dilemma with this interview process was how the interviews could be conducted objectively. I was strongly associated with the executive and accordingly as an ‘insider’ conducting research interviews might have resulted in a politicalised response to questions. The debate between insider and objective roles of the researcher has been discussed earlier in the chapter on methodology. However this part of the research is about recording voice and not about action research. It emphasized the individual’s experience and their subjective reality. Accordingly, I felt that presenting myself as the interviewer created a potential for response bias and for reduced richness of data. To resolve this problem the data collection process was conducted by two contracted



research assistants (funded indirectly by the hospital) and drawn from established research centers at Waterford Institute of Technology.<sup>24</sup> Both assistants were post-graduate research students at the Institute and they conducted the research under my supervision and quality control.

The management of research assistants provides additional challenges in the conduct of research and accordingly a strong research management framework had to be established for the execution of this phase of the research. In line with Yin (2003 a, b), a research protocol instrument was developed (see appendix 8) which clearly laid out both the questions and the expected conduct of the interviewer. The protocol was discussed with each assistant individually and for training purposes each assistant was asked to run through the interview with me. Each interviewer was also given O'Byrne, Angwin and Kavanagh (2005) and the draft text of O'Byrne (2007) to read as background to the case so that they would be familiar with the interviewee's context. The interview protocol was also discussed with the Integration Manager to ensure that language and context was understandable to the participants and that she was satisfied with the direction of the questions.

Prior to conducting the interviews, ethical clearance was sought from the health sector ethics board. This was sought because the data collection process had changed, shifting from a reflective cooperative action research mode (working with management) to a formalized data collection mode where individuals within the hospitals were being interviewed: a move from giving voice to recording

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<sup>24</sup> One of these students had already conducted paid focus group research on behalf of STGH, under my direction, as part of developing the mission statement. It was agreed that in return for conducting the mission statement research the hospital would fund this part of the PhD research. I am very grateful to the hospital for this contribution.

voice. A formal application for approval to conduct the research was submitted and subsequently approved (see appendices 5 and 6 for the submission and letter of approval).

The research was conducted in four blocks to capture pre-merger and post-merger opinions across the two groups. Blocks 1 and 2 consisted of interviews approximately two months pre-amalgamation with staff in the Clonmel hospital and Cashel respectively. Blocks 3 and 4 consisted of interviews approximately five months post-amalgamation<sup>25</sup> with staff previously interviewed in Cashel and Clonmel. The full list of interviews is in the appendix 7. As it was not possible to identify exactly who was transferring from Cashel to the new hospital not all of the interviewees actually transferred and accordingly some individuals could not be interviewed on the second occasion (in addition some staff had left the hospital).

The Integration Manager identified key people in the hospital who would be capable of providing insights on the amalgamation. A cross-section of people was selected on the basis of their involvement and awareness of the integration process. All interviewees were given an information sheet and a consent form to complete. The interviewers collected the consent forms and were instructed not to interview any person who was reluctant (or refused) to sign the consent form. The interviews were conducted in accordance with the protocols and all except one interview were taped and transcribed after the interview. In one instance the tape recorder failed and the interview was not recorded. However the interviewer

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<sup>25</sup> These interviews were conducted later than anticipated due to a national nurse's strike that affected STGH.



had substantial notes taken and immediately after the interview wrote up the notes and her memories of the interview. While not ideal her extensive note-taking provided a sufficient record of the interview for analysis. The duration of the interviews varied substantially with some lasting 20 minutes and others lasting over an hour. Indeed in one instance the interviewee would only give the interview in the ward office while she was on duty and accordingly the interview suffered substantial interruption. Participation in the Cashel interviews (Block 2) were more problematic, in general, than in Clonmel (or South Tipperary General) because staff were often 'too busy' to engage.

Transcribed interviews were input into Nvivo and analysed in accordance with the coding structure created in the financial services study (described in Table 4.2). The analysis of the coding structure was adjusted to reflect the operating environment of a hospital, for instance services set was used in place of product set.

#### ***4.3.4.5 Final Reflections***

The final data collection phase consisted of a number of final discussions conducted with the major participants. This consisted of discussions with the Hospital Manager, the Integration Manager, the director of nursing and the leader of the operations management group through normal meeting interaction within the hospital. The submission by the hospital of the merger process for a health sector sponsored best practice award<sup>26</sup> afforded an opportunity to reflect in a group format with the participants.

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<sup>26</sup> The change effort was presented with a merit award by the Health Service Executive.

A formal review and reflection process occurred in January 2008. The purpose of the reflection was to discuss the amalgamation process and to formally record participant's perceptions of what happened and their reflections on the process as a co-participant in the action research activities. A draft chapter of the hospital case was produced and I met individually with both the Hospital Manager and the Integration Manager to present the chapter to them. I met with them individually to acknowledge authority structures and to allow any sensitive issues or concerns to be raised if necessary. They were each asked to review the chapter with particular emphasis on how the chapter made sense in the context of their own lived experience. A supporting one-page document was also presented to them with a set of key questions that they might consider in their review and reflection. These included checking for accuracy in reporting events and reflections and the value of the analysis and legitimacy of findings. In addition I asked for reflection on the

- boundary framework and how that helped in the merger process;
- our roles and relationships throughout the period of the action research project;
- sustainable learning that had occurred for them, for the hospital management and for the culture and ethos of the hospital more generally.

We agreed that we would meet one week later after the Hospital Manager and Integration Manager had had an opportunity to read the work. I afforded the opportunity to discuss the chapter individually with each or collectively as a



group. Interestingly, and in line with the open approach of our previous teamwork, both expressed a strong preference that the reflection session should occur as a group exercise.

We met in late January for approximately two hours to discuss the work and analysis. The meeting was taped as a record and to assist future recall. The discussion reflected the trust and openness that had emerged between us as a group and provided significant feedback on the value of the action research approach and the learning that had occurred. These are dealt with more fully in the discussion chapter. The discussion strongly endorsed the ‘reality’ of the case description and analysis (notwithstanding some suggested amendments).

Significant contributions to a deeper understanding of the case also emerged as issues of control, trust and the change ‘tipping point’ surfaced in the discussion. This session served both to strengthen the data and the analysis and also as a significant quality check that confirmed the reported analysis had resonance with the lived experience of participants.

#### **4.4 Ensuring Quality in the Collection and Analysis of Action Research**

##### **Data**

A number of steps were taken to ensure that the action research was conducted in line with the quality criteria set out in section 3.8. Table 4.4 assesses the research design based on Herr and Anderson (2005) quality criteria as a means of establishing measures for the final assessment of the thesis.



Table 4.3: Ensuring research quality (based on Herr and Anderson, 2005)

Quality/Validity Criteria	Assessment in the Final Study
Outcome validity	Goal is the merger takes place and positive outcomes achieved
Process validity	Use multiple sources of data and reflection and locate evidence that practices change in hospital and systemic learning occurs
Democratic validity	Philosophy of participation with open opportunity for contribution. Design allows for researcher and practitioners to share understandings within action cycles Researcher and practitioners to co-publish articles and shared reflections
Catalytic validity	Reflection structure and data collection allows impact on the practice of participants and on management on the learning about the hospital
Dialogic validity	Aim to publish work and open to review with external peers

This table demonstrates the breadth of quality measures that are incorporated into the design. In summary the overall quality of the data collection cycle has been ensured by the

1. formalization of each stage of the research process including the formation of interview protocols were appropriate;
2. ongoing involvement and feedback from the co-participants (the hospital management);
3. codification of cycles of actions and the creation of points of reflection;
4. use of multiple sources of data;
5. publishing of findings and ideas.

The involvement of others in the data collection and analysis is a key part of the quality process. Involvement of external and internal stakeholders improves validity of the analysis along process, democratic, catalytic and dialogic validity measures. Similarly, central to the outcome validity measure is the impact that



the research has on the lives and activities of the co-participants and the resolution of the key change issues being addressed. Quality in action research is about opening up the process of research and their reflections to the widest possible audience in order to test and validate conclusions emerging. This research project has had a number of quality checks and process refinements throughout the project. Notably:

1. findings from each stage of the research process were reported to the user communities;
2. co-authored papers have been presented at academic conferences (O'Byrne, Angwin and Kavanagh, 2006 and O'Byrne, Kavanagh and Angwin 2005);
3. the project was presented, by the Hospital Manager and myself, as a working project for analysis and reflection at the action research SPARC<sup>27</sup> workshop in the Academy of Management, Atlanta, 2006.

#### **4.5 Limitations of the Methodology and Methods adopted**

Making choices always involves trade-off between alternatives and accordingly all method decisions involve accepting a balance between the strengths and limitations of methods. Limitations can stem from the philosophical choices made in the ontological and epistemological assumptions adopted, from the instruments selected in the application of those assumptions and from the process of application that may result in weaknesses in the data collected.

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<sup>27</sup> Sustainable Practice Action Research Community

The selection of an interpretative frame is appropriate for this research as it facilitates a deep understanding of a social phenomenon from the perspective of the participants engaging that phenomenon. In adopting this approach, however, the work denies the capacity to generalize across organisations or contexts.

Coupled with this issue is the decision to limit the research to two in-depth studies which enhances our understanding of complexity within the studies but limits our ability to replicate the findings across many other organisations. This trade-off between breadth and depth of study is a classic problem for longitudinal and in-depth case work.

A significant weakness in the action research design is the extent to which participation in the reflection processes achieved wide participation. The action research team primarily consisted of the two most active managers in the hospital and the researcher with occasional input from other senior members of the hospital. The research would have benefited substantially from a wider participation base, especially from greater input from clinicians. More importantly, many branches of action research emphasise that all parties to the decision ought to be engaged in the decision-making if true self-determination and emancipation is to be achieved. While emancipation, per se, is not an objective of this research work, nonetheless it was hoped that wide participation would ensure some level of individual self-determination. The process did achieve a wide participation and a devolved decision making (and sustainable learning in relation to devolved decision making) but only within the context of the industrial relations environment in the hospital. A fuller range of involvement as part of the AR team was not a feature of the work.



A further limitation of the instruments used lies in the use of questionnaires to collect organisation wide data in the hospital study. Questionnaire data are typically used to collect objective facts about objective realities. They are particularly relevant when objective measurements can be imposed on a phenomenon through a predefined schema. No such reality is assumed in this research. It could therefore be argued that the questionnaire instrument is inappropriate for this type of research. The questionnaires were used as instruments to describe events and to judge strength of opinions and identities. They do in no way represent an attempt to create an objective reality. The use of questionnaires to support subjective assessments, for instance in identity research (Haslem, 2001) or values and beliefs (Enz, 1986), are commonplace.

The multi-method approach adopted draws on many instruments of data collection. A clear limitation within the work however is that their ideal application, particularly within the hospital study, was often compromised because of the 'real-time' events and timeframes that emerged. For instance the interview data collection was originally scheduled to take place three months pre and three months post-merger. In reality it occurred six-eight weeks pre-merger and six months post-merger due to uncertainty in the actual timing of the merger (only 12 weeks notice was actually given) and industrial relations problems that delayed the second series of data collection. Similarly, the response rates to the first questionnaire were extremely low and this challenges the confidence in the conclusions drawn. However the strength of the multi-method design is that confirmation of the data is evident in other data sources. Several weaknesses are

evident, on reflection, in the questionnaire collection. The distribution method (circulated with payslip) did not result in all staff receiving the questionnaire, for example it became evident that not all staff collected their payslip<sup>28</sup> and while it theoretically accessed all the staff being paid by the hospitals, many other groups of people (paid by central head office or other organisations) also considered themselves (and were considered) as part of the community of the hospital. A second problem was that the questionnaire got linked to a political process and was seen as a means of collecting data on the amalgamation at a time when industrial relations were problematic. This was a specific reason why many staff failed to respond, especially in Cashel. Substantial learning occurred from the application of the first questionnaire and the second questionnaire avoided the limitations and resulted in a substantially increased response.

A further weakness of the data in both the hospital and financial services study was that the longitudinal consistency achieved through the interviewing of the same people over two timeframes was problematic. Perhaps because of the nature of the M&A task and the uncertainty, stress and staff turnover often associated with M&As, the number of respondents who were available for the second round of interviews was lower than anticipated in each study. This reduced the reliability of understanding in how contexts change in the views of each individual and increased the need to assess for consistency across informants within each set of interviews as well as across time periods.

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<sup>28</sup> When checked it was noted that payslips were not collected from their distribution point for many staff.



Finally, it could be argued that the study traverses two distinct sectors, private and public organisations. Differences exist between these sectors in terms of HR structures, strategic orientation, resource availability and personal commitment (La Piana and Hayes, 2005; Shield et al, 2002). It might therefore be argued that theory developed in one sector is not readily transferable to the other and that the theory development process might have been tighter if two similar organisations were chosen for study. However, this work is concerned with intra-organisational inter-group behaviour and no direct comparative analysis is intended between the two organisations. The phenomenon addressed is group behaviour within a particular setting, recognizing that all settings are unique and socially constructed. While it might be ‘analytically nicer’ to have similar organisations the relevance of the two studies remains consistent in their study of similar phenomenon at the group level. In this respect the public-private divide is not significant for the research question.

#### **4.6 Conclusion**

This chapter has established the steps taken within the method. Two studies are conducted. The first is a longitudinal case study designed to develop the theoretical construct of boundaries. The study consists of three sets of merging branches studied over differing time frames. This study achieves on the second pillar of the research design developing theory from the field.

The second study applies the boundary construct in practice by conducting a five year action research study. The study engages four cycles of diagnosing-action-reflection and uses multiple sources of data including reflections, interviews and

questionnaire data. The complexity of the data collection cycles has led to a number of weaknesses including the extent to which the theory is generalisable and the extent of participation achieved as well as instrument-specific weaknesses. Overall however the design has been consistent with the Herr and Anderson (2005) criteria for assessing quality in action research and specific actions designed to deliver quality across all five of their dimensions are achieved.

The next chapters (5 to 9) will explore the data that was collected in the studies and present the theory development process in line with the design expressed in table 1.1.



## **5 Building theory from fieldwork: The Financial Services Study**

### **5.1 Introduction**

This chapter addresses the second pillar of theory development identified at the outset of this thesis. It will build on our theoretical understanding of boundaries developed in chapter 2 by identifying what boundaries exist in a merger and explaining how management interventions impact on those boundaries.

Combined with the next chapter (the discussion of the case) this chapter will expand on the boundary framework (table 2.4) to allow it inform the action research pillar of the research design (chapter 7).

The chapter sets out the data collected in the study of three separate sets of branches merging as part of a major financial services merger. It describes the case context and the outcomes of the merger and then will consider the types of boundaries that had potential to emerge in the case and discuss how these potential differences were managed. The boundary framework described in the literature review had strong resonance in the study and the analysis succeeds in identifying specific boundaries for each of the three classifications. The data reported in this section consist of transcript analysis of 15 interviews with staff directly involved in the amalgamation process. The chapter is written as a data chapter laying out the data and opening up the data to allow the reader to see how the findings of the case have emerged. The discussion and analysis of the findings will be presented in the next chapter.

## 5.2 The Case Study and its Context

Retail Company,<sup>29</sup> a reasonably small financial services company operating within a medium-sized European country, was acquired by Contract and Capital Sales in early 1999. Retail specialised in a consumer sector of the market. It had a head office structure and 82 branches throughout the country with a staff well in excess of 1000. The business concentrated on day-to-day products and services used on a frequent and regular basis by the customer. The company resold some of the products of Contract and Capital but also resold many competing offerings. Retail had been aware that they needed greater scale and scope to compete in an ever more competitive market and had been the target of several suitors prior to the acceptance of the Contract and Capital deal.

The Contract and Capital group emerged from the merger of Contract Ltd and Capital Ltd some years previously. Both firms were market leaders in their segments of the market. While the Capital Co, had some retail operations it still remained focused on capital (long-term) products. The firm had a national coverage with 70 branches. A major hindrance to developing its retail operations was the lack of direct access to some parts of the distribution system. This access was a critical factor in the delivery of effective services to the customer. Indeed Contract and Capital was using a competitor to provide these services resulting in longer work-cycle times, slower services to the customer and greater cost.

The strategic logic behind the acquisition of Retail was reasonably simple yet very powerful. By merging the Capital and Retail operations into one large retail

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<sup>29</sup> All names of companies, persons and dates have been altered to provide informants with anonymity.



force it would enjoy full access to the distribution system and have the scale and product ranges to compete effectively within the industry. This new force would also be a tied agent for Contract's products increasing the capacity to cross-sell services and products. While there would be some cost efficiencies from the elimination of duplicate head office and support functions and from the rationalisation, the real value of the deal was the capacity to offer an extended range of products to a wider customer base. This extended range of products would emerge from combining the best products and processes from each firm.

### *5.2.1 The Organisational Cultures*

On the surface the cultures of the two combining organisations looked similar. Both organisations espoused the importance of customer service and commitment to providing quality services. Capital was however very focused on achieving volume and aggressively selling their product ranges. In contrast Retail focused more on the long-term relationship with the customer and was more service-focused (and facilitating) in the way it sold its product range. It was more risk adverse and procedural-driven than Capital. There was a feeling that Retail staff were more favourably positioned than Capital staff, they had substantial benefits from an employee share-option scheme, had better terms and working conditions and were likely to dominate the amalgamation given the retail orientation. The integration management allocated considerable resources to the development of cultural understanding through significant investment in communication and intra-organisational contacts. These contacts took the form of training in products/services, pre-branch amalgamation meetings and forums,

and local social events. Many additional events were also organised by local branch managers.

### *5.2.2 The Branch Network*

One of the major challenges in achieving the strategic goals was designing and implementing an effective branch network. Combined the group operated a total branch network of 150 branches and this was to reduce by about 40 branches to 110. Some branches were located in close proximity to one another and were easily identified as mergeable. The product range adopted by the new firm built on the strengths of each partner with the main products of each selected as the new firms offering. Both organisations therefore retained what they would have seen as their key products. Decisions regarding the technical infrastructure such as IT systems also logically followed from the key strengths. Key technical issues had to be resolved to facilitate this technology combination and dual systems using both Retail and Capital systems operated for several months before a unified IT system was adopted. Branch amalgamations were undertaken on a phased basis commencing in November and ending in the following May. A key element of this phased process was the ability of the integration team to ‘learn’ about the issues and problems on a phased basis and adjust their preparation for each additional branch amalgamation in the face of this experience.

### *5.2.3 The Outcome of the Merger*

Sixteen months after the acquisition had been approved, and almost two years after the initial offer, the new organisation (Capital and Retail) had amalgamated



its branch network and its support structures. Its success was summed up in a press interview by the director who headed the new firm when he stated that the merger was ‘as close to a textbook merger as you can get’. Difficulties were acknowledged, however, especially around the nature of customer service which given the demands on staff may not have been as good as it should have been. But generally the integration of the two organisations as a whole had gone according to plan and the financial outlook for the firm was very positive.

### **5.3 Aims of the Bank Study**

The objectives of the financial services study, as outlined in Chapter 3, are:

1. To identify the broad categories of boundaries which present the potential to become salient within a merger;
2. To explore how the boundary categories may be managed to reduce the potential for them to create salient differences within the amalgamation.
3. To suggest a model of boundary management that is capable of being applied in an action research mode to manage an actual amalgamation.

### **5.4 Types of Boundaries**

Boundaries have been operationalised as perceived differences and are classified into physical, behavioural and cognitive categories. Physical differences are tangible aspects of difference that had a physical (or special) manifestation.

Behavioural boundaries are differences in the way staff executed their duties and the differences in the expectations of behaviour within a particular setting or relationship. Cognitive boundaries are differences in the way staff think about issues. They were represented by the cognitive processes behind actions: the way

the staff created a logical interpretation of their work environment. Sections 5.5 to 5.7 will expand on these categories and explore the boundaries that existed within the financial services merger in each of these categories. The purpose is to identify what boundaries actually exist and to understand how each boundary type was affected by management interventions.

**5.5 Physical Boundaries**

Physical differences were the easiest to identify and the highest volume of coding related to this type of boundary. This should not be surprising as the physical manifestations of differences are probably more obvious, more visible and more readily identifiable by the participants. They also had a more frequent impact on the staff and occurred more frequently in the daily activities of the branch. Seven potential physical boundaries appeared in the data. These are listed in table 5.1.

Table 5.1 Physical boundaries in the financial study

Boundary Type	Overall Totals (n = 15)		Capital (n = 6)		Retail Co. (n = 9)	
	Informants Referencing	Passages Coded	Informants Referencing	Passages Coded	Informants Referencing	Passages Coded
Job description	12	26	4	13	8	13
Product set	13	29	5	10	8	19
Location	13	35	5	20	8	15
People	10	32	4	17	6	15
Owners	8	25	3	7	5	18
IT system	13	26	5	12	8	14
Branch manager	14	58	6	32	8	26

**5.5.1 Job Description**

There were substantial differences in the ‘terms and conditions’ of employment in both organisations and the related issues of organising and scheduling of work. This node was termed ‘job description’ to represent the overall framework of the



work context in which the staff were embedded and was typified by differences in hours worked, length of day or holiday entitlements.

A number of specific issues presented significant potential for boundary problems to emerge. A primary issue was the hours of work. In Retail the branches remained open late on a Thursday until 7.00pm for which staff received 'rota-days,' an additional two days leave a month. In contrast Capital worked a standard week. When the branches merged staff was

*“working on two different playing fields..... You're trying to run a branch, a set of staff together, that work off two different terms and conditions” (Assistant Manager Retail, Branch 2).*

A temporary solution to the rota-day was that Capital staff was asked to work the additional time and claim time off in lieu. However this resulted in the Capital staff getting one day a month leave rather than the two given to the Retail staff. This resulted in some feelings of inequity.

*“I personally think that the merger should never, we should never have been allowed to merge unless the terms and conditions were sorted out because at the end of the day people are only human and if you see someone who's not working as long as you are getting a day off every two weeks you kind of say to yourself well why should I bother. .... I think that that is the one thing that we are definitely not Capital and Retail. (Assistant Manager Capital, Branch 1).*

Ultimately the issue was resolved through the elimination of the late night working on Thursday. However this solution was only agreed 18 months after the first branches began to merge.

In addition to the rota-day there were other aspects of the terms and conditions that differed. For instance starting times, lunch times and holiday arrangements created two very separate groups within each branch.

*We all have different starting times. Like we'll take for instance now the late working on Thursdays you'll find that some staff don't start until 10 to 10 in the morning. Now we start at quarter-past-nine (Assistant-Manager Capital, Branch1).*

*I still look after the day-to-day attendance records and all that for the Retail side, whereas [name] after them for Capital and I suppose that can't be merged until the terms and conditions [are agreed]..... even from the minute you walk in the door in the morning it's [Capital] person signs in there and well I look after the Retail people, we've a different method of doing it (Assistant Manager Retail, Branch1).*

*They were simple things alhhh like holidays. ....in Capital, the holiday calendar was open and in the former Retail it was on the year's service you had built up. It wasn't my fault you were 20 years in the branch. I felt that the holiday calendar was open to everyone. That was a grey area, we resolved that down the line (Staff Capital, Branch 3 – speaking of another branch).*

A third aspect of the job description boundary was the informal conditions of working within the branch such as tea-break protocol, smoking and car parking. These were often seen, particularly by the branch managers, as *mundane things* (Manager, Branch 3).

*All the small little things, it's amazing how people think, you'd imagine the job security and the advancement would be the big thing but in fact for a lot of people it is the smallest thing that would concern them, it's amazing (Manager, Retail Branch 1 ).*

While not a specific legislated condition of work these informal rules had impacts on the physical conditions, nonetheless.

*Another issue that came up was that there are a few of us who smoke and basically it was portrayed before they came down that 'we didn't agree' with smoking. Which is fair enough I suppose. We don't want smoking in the kitchen. So a few of us, ended up being exiled, like every tea break and lunch time, .... but it was just a small thing, it was fine, we conformed (Assistant Manager Retail, Branch 3).*

*You weren't sure like simple things like where did you get to park your car, they had a car park, we didn't, we weren't told we couldn't use it, then again we weren't told we could use it (Staff Capital, Branch 3).*



An interesting aspect of the job description boundary was that it was seen to emerge outside the branch network, being the responsibility of the unions and head office management. This was very evident in sentiments such as “*it would really go to show you how weak the unions are to allow it to happen (Assistant Manager Capital, Branch 1)*” or *there are five different unions and that’s a big problem (Staff Capital, Branch 3)*.

Job description boundaries created a huge degree of uncertainty as staff struggled to become familiar with their new work terms and conditions. This was particularly evident in respect of the informal conditions of working such as tea break protocol, smoking protocols and car parking. While these were often small and mundane issues they nonetheless created a significant number of problems for the branch managers as staff took time to familiarise and accustom themselves with their changed environment. In this respect job description had the potential to create boundaries because staff was unfamiliar with the structures around them, both formal and informal. They create tensions over the loss of, or changes to, familiar task structures that existed in the pre-merger organisation and their need to understand these new structures.

### 5.5.2 *Product Set*<sup>30</sup>

Closely linked to the notion of the job description is the range of products and services. This was one of the most clearly identified differences between the two organisations and is probably to be expected given the close relationship between the product and the daily duties of the staff. Each organisation was recognized as strong in a defined product range. Capital was strong in long-term lending and in

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<sup>30</sup> The exact products of the organisations will not be specified so generic terms like short-term lending and long-term lending will be used. This is to ensure the anonymity of the organisations.

bank assurance and life assurance products. Retail were strong in general banking including current accounts, short-term lending and personal banking services.

*We were very strong in the [long-term lending] market, they weren't. We weren't strong on the [personal banking] market, they were. So there is probably a natural progression that went down that road, we could cross-sell our [long-term lending] products and they would be able to get our customers into the [personal banking] (Staff Capital, Branch 3).*

*There is no doubt that Capital are bringing a far stronger [long-term lending] presence to the party and we have to kind of bow down to their experience in that regard if you like in so far in that while we have done [long-term lending] and we have been very successful in the [long-term lending] area, they were the No. 1 [long-term lending] provider in the country or close on, so, that was their primary strength our strength was in our personal banking, I felt, in our ability to deal with the retail side of the personal sector (Manager Retail, Branch 1).*

Product set also relates to product knowledge and procedures for how the products were sold to meet customer needs. Retail operated in daily banking activities with emphasis on short-term products and unsecured lending while Capital operated in the long-term lending market emphasizing longer-term products and secured lending. The product skill set therefore typically revolved around secured versus unsecured lending and day-to-day versus longer term requirements.

*You would have to say that's because Retail are better at the unsecured lending. But then again most of our lending in the former Retail was unsecured lending. So I suppose we had to learn how they did their unsecured lending and how they operated from that basis (Staff Capital, Branch 3).*

*There is a very big skills gap, the way I would see it, in the branch at the moment, the former Capital did [long-term lending] and savings and investments and they didn't have, they didn't really have working accounts business [and personal] accounts that sort of thing and that's the main tranche of your workload in any given day (Assistant Manager Capital, Branch 2).*



Product differences were also very clear even in the underlying ‘best of both’ concept underpinning the integration process. Documentation arising from the integration office often extolled the virtue of the organisations along product lines, creating clearly demarcated product territories.

A very common description of the two organisations was along the lines of ‘Bank’ (Retail) versus ‘Building Society’ (Capital) and the associated product set that fits with each description. Indeed the product range formed a source of identification with the organisation, with staff often referring to themselves in the context of the product base, for example as [long-term] lender or [personal-banking] lender. There were very strong and consistent descriptors of this boundary across all of the interviews conducted.

*Capital was in my view a former building society, they did [long-term lending], they did car finance, but they dealt with brokers and an awful lot of their businesses came from brokerages. So we’re totally different, we dealt with mortgages, fair enough, but we would have been a big [long-term lending] lender in the town but we also dealt with [personal banking] and business accounts and they wouldn’t have had any experience of that side of things, ..... It’s a totally different product base (Assistant Manager Retail, Branch 3).*

*Capital wasn’t for the want of a better expression a true bank (Assistant Manager Capital, Branch 1)*

Similar to job descriptions, differences in the range of products and services offered by the branches also created tensions. There was a close relationship between the product and the daily duties of the staff with each organisation identifying strongly with their product set. Capital was very proud of its heritage and its position as market leader in its field. It identified strongly with its sales offerings and defined itself in terms of its capital-based products. Its staff was less comfortable with banking products and preferred to remain post-merger

servicing the same product range. Similarly, Retail provided a retail service and felt it had far better products in the retail sector than Capital. While the specialisms facilitated the decisions about what products would be sold in the new organisation, long-term lending products was selected from Capital and retail products was selected from Retail, the specialization of staff in their field of expertise supported a boundary between the organisations and tension about what exactly the other organisation products were. In this way the product set produces the potential for boundaries to emerge from the differences in physical products and knowledge. The adoption of a new product set creates a tension based on the unfamiliarity of the new products and an understanding of what they are and what product knowledge is required to effectively sell them. The case further demonstrates this fact as most of the staff in the branches remained in their 'comfort zone' of products despite the availability of training and opportunities to learn about the new products.

### *5.5.3 Location*

The third potential physical boundary related to the location and layout of the branches. The amalgamation of branches took place in approximately forty locations around the country. A process of evaluating each location and deciding whether the Capital or Retail branch would be selected as the amalgamated branch, based on the business case, was completed. Given the retail focus of the new organisation the Retail branch was selected in most cases as the new sales outlet. To staff the branch presented a strong physical symbol for each organisation. The merger impacted on both sets of staff. Staff moving from their



branch had to get to know a new office layout while those that remained in their branch had a large number of additional people within their branch.

There was strong attachment with the physical premises and several references to 'lovely offices' (Assistant Manager Capital, Branch 1) or 'even though it was building and stone, you always felt you knew the ins and outs of it' (Staff Capital, Branch 3). There was a clear sense of loss associated with the movement from one branch to another and it created a sense of uneasiness for the staff that were due to move.

*It wasn't easy for the lads to leave their own branch, their own environment, their own mugs or whatever and come down to this branch (Assistant Manager Retail, Branch 3).*

*Coming to a new place, they very much, felt like welcome to our branch, but it was ours as much as theirs.... A lot of people felt uneasy, like I felt uneasy myself, you know like simple things: where is the kitchen? Where is the bathroom? Is this going to work? (Staff Capital, Branch 3).*

*Oh definitely I would prefer to be staying put than having [to move]. We don't envy them having to move up here (Assistant Manager Capital, Branch 2).*

The premises provided a clear tangible location for the branch's activities and it was perceived that the layout suited the activities of the branch.

*We were a concept branch and this wouldn't be a concept branch. They would, we didn't have any bars or any restraints whereas here we would have (Staff Capital, Branch 1).*

*The banking area in particular is going to be.. we all feel it's going to be a major problem because they don't have queues as such, might have a queue an odd time during the day. We could have queues here all day. Where are all these people going to fit. You cannot fit all these people into that area so I think they have kind of forgot about the queue (Staff Retail, Branch 2).*

*The big difference, the physical layout of the building was different it was much more of an open plan kind of relaxed kind of an atmosphere up there (Manager Retail, Branch 3).*

There were also strong affinities and associations with the general physical environment of the premises. This manifested itself in concerns about the layout, its suitability, the staff desk positions or indeed items of furniture. A good example of this arose when one branch staff insisted that a large filing cabinet, too large to fit in the new branch, must be moved to the new location. Ultimately the cabinet was moved to the new premises where it remained for almost a year before being finally removed.

*The big issue was a filing cabinet. That was before the day they moved down. It was huge, [the manager] was out that week and they wanted to bring this huge big filing cabinet down, and me probably being a bit black and white, went oh well it's not going to fit, so what's the point we will be all tripping over it. But it was like the Holy Grail to them. They wanted it and it caused murder here. I remember ringing the Assistant Manager saying it just won't fit so what are we going to do with it? Well the lads really want it. And I just thought it was ridiculous at the time but then again there was obviously in hindsight a lot more than the filing cabinet issue, it was a piece of them, they just wanted it, it was like a comfort blanket to them I suppose (Assistant Manager Retail, Branch 3).*

A fear among the two sets of staff was that the location might in some way perpetuate a perception of continuity within the old branch or the perception that one side would dominate the merger. For instance one staff member of Capital suggested *that her opinion may be not as much taken on board because they are still here in the same office they were in three years ago, still trying to run the business as it was done three years ago.*

This fear was particularly relevant given that the majority of branch transfers arose from the transfer out of Capital buildings to Retail buildings, and this coincided with a move to more of a retail bank focus, suggesting a domination of the merger by Retail.



In summary, the movement to a new or altered building creates a tension about the unfamiliarity of the building environment. Staff must get familiar with the layout and structure of the physical environment and deal with the changes from the old structure. Even where the staff remained in the building the changes made to facilitate the additional staff resulted in changes to their physical layout. Space provides familiarity, association and comfort for the staff. Tensions emerge due to the surroundings changing and the need to re-acclimatise to the new layout. Location has the potential for boundary until the sense of comfort is reaffirmed in the new location as staff get acquainted with the surroundings and accept them as adequate to their needs and tasks.

#### 5.5.4 *Colleagues*

Colleagues as a potential boundary refer to the physical make-up and structure of the staff within the branch and how the amalgamation of the branches alters the team make-up. The clearest example of this was in the size of the branch. In the studies there were significant differences in branch sizes post amalgamation. The informants viewed this as a move from being a ‘small’ branch to a larger branch with concomitant implications for the team structure and make-up within the branch.

*There was a max of nine staff in the branch at one time. Now all of a sudden it's going to be up to eighteen or nineteen you know so it's a bigger group (Staff Capital, Branch 2).*

The effect of this potential boundary was to challenge the relationships that appeared to exist within the branches often described in terms of family. We were all *one happy little family* (Staff Capital, Branch 2) or as a *nice little cosy*

*branch (Staff Retail, Branch 2) or we've normally had about eight to nine staff so it's fairly close knit, not too big (Manager Retail, Branch 2). There was a strong desire that the family environment should be maintained and that staff would quickly get to know one another and get on.*

*..even if you just put a face to a name you're not coming in on the first day of working and you don't even know who your comrade is or what they do or where they're supposed to be sitting or whose desk is it or who do you go to for a signatory or something like this (Staff Capital, Branch 1).*

*The integration of the staff was a big one and it has as I said worked out well' I mean there were five new staff came in here. I didn't know any of them I'd never laid eyes on them (Assistant Manager Retail, Branch 1).*

The corollary of this 'family' effect was the sense of loss that was felt with the changes in colleagues. *We were being torn asunder so much. Some of our staff have gone, a lot of staff turnover in the last year or so and the staff have gone, [our manager] is gone, staff have gone on maternity leave, things like that (Staff Capital, Branch 2).* The importance of this sense of loss was to drive the existing team more tightly together and strengthen the team.

*They were extremely anxious to hold together. They saw themselves as a kind of a little band and they didn't want to break that and they didn't want a situation where let's say half of them were moved in here and that the other half were dispersed to various branches and various other Retail branches and didn't have the support of their former colleagues..... When they came in first it was like a group of people coming in holding hands. If you want to create an image and they were very close and you could see it and you could see that there was a kind of a bond there that they were going to support each other (Manager Retail, Branch 1).*

Colleagues provides potential for boundary salience due to the need to become familiar with a new group of people who join the existing team. Until such time as the new team members cease to be unfamiliar there is a potential for the groups to polarise and reject the other group's members. There was a pressure



and tension in the case for each group to get to know one another before the physical amalgamation of the two groups.

#### 5.5.5 Owners

The ownership structures of the two organisations offered another potential for a boundary to emerge. Ownership as a physical boundary relates to the physical manifestation of who owns the organisation. This was a slightly unique boundary in that it represented a difference not between the two combining organisations but between them and external shareholders. This was particularly evident in the case of Retail who had a semi-state-style governance structure. The company's management reported to a board of trustees rather than a commercially focused shareholder-based body. In the new merged structure Capital and Retail became a trading arm of Capital and Contract PLC, a large publicly quoted company. This shift to shareholder accountability was a huge issue for the Retail staff and had major perceived implications for the type of job the branch would be required to perform.

*We work for shareholders now (manager Retail, Branch 1).*

*Bottom line its all down to costs. That's the way I look at it. And I know, ok its profit and its shareholder and all that. And that's who were are responsible to now and it's all down to profit (Assistant Manager Retail, Branch 3).*

In addition to the concerns of the Retail staff Capital also felt a sense of pressure and control being exercised from the parent company.

*It [the parent co] own the company now and they want this done by hook or by crook so it's going to happen .....You work for [name] company, they're in it for profits, you know. I think the day you stop remembering that is you're only useful as long they want you (Staff Capital, Branch 2).*

*At the end of the day you're dealing with shareholders ..... the big thing obviously, a return on their investment so if they feel that a branch isn't towing the line and isn't making a profit obviously well they're just gone. You know, that's the way everybody thinks basically. When you're answerable to shareholders at the end of the day they're the ones who employ [you] (Assistant Manager Capital, Branch 1).*

A strong theme running through the descriptions of the new ownership structure was the sense of how the new ownership structure represented a loss of control with the product offerings and procedures being driven by the parent company often at the expense of the traditional operations of the pre-merged organisations. There was a very strong feeling that only assurance sales were important and that the [long-term lending] or [personal banking] products were playing second to the bank assurance products and that this was being driven by the need to satisfy shareholders.

*I was with Capital when it became Contract and Capital PLC and you definitely see influences coming in from when we, when Capital, merged with Contract you certainly saw Contract influences come in and the fact that bank assurance became more a key player in your day-to-day business (Staff Capital, Branch 2).*

*I suppose the big fear and it is still articulated quite a bit is what impact being owned by a life assurance business is going to mean to us. That's in effect what the business is now, owned by a life assurance company. There is, was, a big fear that it was only going to be about life assurance and that they were going to get as much as possible out of us and then move on.. and I have to say that that fear was confirmed by Contract and Capital who had been through a similar process some years previously. So that was a huge concern that people felt these boys are going to be interested in selling life assurance and they don't care about anything else. Retail has a huge customer base so this is seen as an opportunity to mine that customer base for whatever it's worth and then move on. (Manager Retail, Branch 3).*

The impact of this loss of ownership control was very evident in two related issues. Firstly there was a general sense that the new symbols of ownership, the shareholders and the head office management, were impersonal and distant and



had altered the family structure of the branch through their interventions, which in turn reduced the loyalty or commitment of staff.

*It's gone [family culture] because we are now part of a group and that group is faceless to a certain extent, well it is faceless you know. We work for shareholders now and you can see that in staff attitude now as well. (Manager Retail, Branch 1).*

*Part of the merger team appeared and suddenly your job load was being defined. That's kind of scary to watch somebody, who doesn't know you from Adam putting your little name in you know. And I mean that's the other thing we have our managers here who are very familiar with the individuals and suddenly then you can see them kind of losing control and allowing themselves to lose control and allowing all these people and there is about three or four of them, all deciding what you should be doing. So the fear factor also for us is that we're being sold down the river (Staff Retail, Branch 2).*

The second effect of the change of ownership was that the Contract and Capital group and the shareholders, while accepted by Capital and Retail, became the focus of criticism for their values and beliefs. In a very direct way they became an enemy of what both Capital and Retail stood for prior to being acquired by Contract.

*[Contract] are probably seen to be an enemy by a lot of them [staff] to be honest (Manager Retail, Branch 3).*

*The big arm of [Contract] hangs over us all (Manager Retail, Branch 3).*

*You're only useful as long they want you (Assistant Manager Capital, Branch 2).*

*Do you know who the Borg are? [Contract] are the Borg<sup>31</sup> (Manager Retail, Branch 1).*

Owners provide a potential boundary by creating unfamiliar demands on the staff as to performance expectations at an organisation level. The perception of what

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<sup>31</sup> The Borg is a reference to the TV series Star Trek. The Borg is an alien species who assimilate entire races into their own form, a collective with a common purpose, common voice and completely unified values where no individuality is possible.

the management of the firm requires becomes unfamiliar and staff must cope with a tension between old and new demands from the owners.

#### 5.5.6 IT System

The IT system was a potential boundary because of the role IT systems play as an interface for staff to access their work and to perform their duties. The IT system created a strong association with the daily activities of the staff and provided a sense of familiarity of routines for staff. Indeed the IT system provided the most physical and tangible representation of the activities of staff, given that they used the IT systems as an integral part of all of the branch activities. There was strong ownership by staff and a great sense of loss where it was being lost. The loss of the IT system was even seen in terms of losing identity: *'we were losing ours [IT system] so we felt ... we were losing a little bit of our identity (Assistant Manager Capital Branch 1)*. Each group clearly felt that their system (probably because of their familiarity with it) was better than the other.

*It (the IT system) is going to have to be an area that they have to get on and stop this yours and ours. And your system is not as good as our system you know. All of a sudden it's Capital and Retail system. It's everybody's system now (Staff Capital, Branch 2).*

*It was difficult for them and they have adapted well. They had to adapt to a new computer system in it that the counter stuff is done on our system now which wasn't easy..... their [long-term lending] process ..... to them they see it as the be-all and end-all (Assistant Manager Retail, Branch 1).*

Changes in IT appeared to signify changes in the very fabric of the work environment and changes in the systems affected the confidence of the staff to perform their duties.



*Because we're moving into a branch that used a different system you're going to have to learn it. You're not going to have the same confidence that you would have had using a system that you know back to front (Staff Capital, Branch 1).*

*I'm only in the company three years but it's like moving jobs to me because I have to learn because the Retail systems are being brought forward and the only part of Contract and Capital that's being brought forward is their [long-term lending] system and our car- loan system. Well everything else, our enquiry screens and our cash transactions, it's all new to us. So to the eight or nine staff of Capital it's like starting a whole new job because they have a whole new system to get used to (Staff Capital, Branch 2)*

The IT system represented a core tool of the daily operations and changes required in the IT system represented a change to a familiar tool of work. Changes to the IT system created a tension for staff as they struggled to learn a new system and become familiar and competent in using the system.

#### *5.5.7 The Branch Manager*

One of the strongest physical manifestations of the branch and its boundary with other branches was the branch manager. Of the 15 staff interviews conducted 14 (93% of respondents) referenced the leadership and 58 passages of text (25% of all physical boundary coding) were coded to this node. The branch manager represented a strong symbol of leadership. The loss of the branch manager was considered by all informants to be a key issue for staff. The informants considered their manager as a mentor and provider of support to the branch team. They held tacit knowledge about staff performance and branch operations. There was a significant feeling of loss when the branch manager was replaced and a great sense of uncertainty about the new manager and trepidation in getting to

know the way the new manager would lead the branch and the extent to which they could be trusted

*Definitely, we all wanted... (pause)... better the devil you know than the devil you don't. It's a strong way to put it but yes certainly we, everyone I'm sure they were the same. We were all apprehensive thinking Oh My God what if he doesn't get it like who is this guy. He won't know any of us from Adam, what we were capable of you know so we were totally relieved like when he got it..... they (Capital) were disappointed of course, they were you know that's understandable (Staff Retail, Branch 2).*

*We don't know what this guy [new manager] is like. We don't know how far we can push him or bring things to his attention or what's his thinking on this like. [Our manager's] thinking on a loan might be totally different to [new managers], that kind of thing (Staff Capital, Branch 2).*

*I think there for a while we all felt who do we turn to because it's all Retail personnel in positions that we would have been dealing with Capital personnel and that was I think a big block for a lot of people and we didn't know these people, could we trust them. Could you go to them about a complaint about a Retail person, and not have it go back to them (Assistant Manager Capital, Branch 1).*

An important aspect of the manager's role appeared to be the direction and leadership, on an individual level, that the staff derived from the manager. There was a familiarity with, and clear awareness, of the manager's expectations

*We had a manager, he was here from the start and then he left which was a very, it was an impact to me. Anyway I felt very hard losing him as a manager because you get to know somebody you get to know their ways and means you know how to approach them whereas now we have a new manager to get used to (Staff Capital, Branch 2).*

*Obviously if you were working with a manager for the last 10 or 11 years and all of sudden they were gone you know it's a big change (Assistant Manager Capital, Branch 1).*

A third aspect of the manager's position was the interpretation of the manager as representing one side over the other, that s/he might have a preference for one set of staff or that decisions would be made that favoured one branch system over



the other. In this respect the manager became a clear symbol of the branch of origin.

*It's probably a threat to them that the Retail management team is coming in as the management now of the new branch. There is nobody kind of plugging for them at their end and that's a genuine concern. I can understand that concern, you know I'd probably be thinking the same if I was in their shoes (Assistant Manager Retail, Branch 2).*

*Obviously you might have slightly more Retail influence considering that really the manager is from the Retail side and .... they'll probably stick to doing things as they did it for a while (Assistant Manager Capital, Branch 2).*

The appointment of the managers also had impacts in the assessment of the degree of fairness and justice the staff attributed to the integration management. There was a sense among the Capital staff that their managers were not given a fair chance at the manager's position given that nearly all the appointments nationwide were former Retail managers.

*We felt that the former Capital managers were actually shafted. That was actually...how they appointed managers was never actually told to the former Capital staff. Whether they reapplied for their jobs ahmmmm... how some managers who were maybe in their jobs only a year and they .. former Capital managers for 20 years, lost his job. We couldn't fathom it. Who made that decision? Was there a golden handshake when retail decide, yea right you can have this. Contract can take over Retail on the strength of a, b, c, d, e, is done and these conditions are met. There is no doubt that things were probably done fair but it begs the question how come all the Capital managers lost their job and not one of the former Retail managers lost his job (Staff Capital, Branch 3).*

The leader provided a strong basis for boundary demarcation as a physical symbol of branch direction and leadership. Changes in leadership created a tension due to a sense of unfamiliarity with the personality and direction the manager was likely to take the branch and the value set the manager would bring to bear on the team. This boundary further relates to the sense of power, control and reward that arises from having access to the powerful with the branch (the

manager) and understanding how their values and mode of operations impacts on branch decisions.

**5.6 Behavioural Boundaries**

Behavioural boundaries arise from differences in the acts or actions that are acceptable or expected within a given context. The data suggests that four types of behavioural boundaries were possible within the case and these reflected the relationship of the individual to themselves, the relationships to the work tasks, the relationship to their work group and the relationship to the customer.

Relationships are an important part of behaviour because they define expectations in respect of other groups or individuals with whom we interact or form part of our own self identity. Clear norms of behaviour were evident in the data. The four categories that emerged from the data are presented in Table 5.2 along with the number of informants referencing them and extent of references represented by the number of passages coded.

Table 5.2 Behavioural boundaries in the financial study

Boundary Type	Overall Totals (n = 15)		Capital (n = 6)		Retail (n = 9)	
	Informants Referencing	Passages Coded	Informants Referencing	Passages Coded	Informants Referencing	Passages Coded
Personal Investment	10	25	5	13	5	12
Work Processes	14	71	6	34	8	37
Team Behaviour	15	62	6	34	9	28
Customer Service	14	26	5	7	9	19

**5.6.1 Personal Investment**

The personal investment boundary relates to the commitment that a member of staff is willing to invest in their work. This was coded in terms of the amount of time they are willing to spend over and above their standard day, their



commitment to making the branch work effectively, the extra volume of work they were willing to take on and the belief that an input/reward process exists that specifies the level of investment that is appropriate for a given position/task. Personal investment represented the relationship of the informant to their 'work self' and is manifest in the level of commitment to working harder for either self- or group-focused reward. There were significant references to commitment in terms of the individual's time investment or expressions that extra work was needed to get the group over the initial problems of the amalgamation. This was evident in the workload staff endured. Workload was often expressed in relationship to the other branch staff's lack of willingness to give similar commitments to work and was considered as 'unrealistic' or 'foolish'. This presented both a justification for a positive self-image that differentiates the person for the other groups but also justifies a reduction of the potential commitment going forward.

*I was working ridiculous hours here and actually they thought I was a fool. What kind of idiot is your one at all. They just didn't seem happy with that [level of] commitment (Assistant Manager Retail, Branch 3).*

*We are so busy and we have this branch has always been short of staff and I have often gone without my tea break and very short lunch break because Jesus I have to get back and do that before the end of business or whatever. Whereas I remember going up to [other branch] to one of the lads in Retail and I wanted to do a term loan. This was their system and I wanted to learn how to do it and I wanted to do it there and it was quarter to two and he was going to lunch at two o'clock and there was no way he would see me for the ten minutes it was going to take, five minutes into his lunch [Staff Capital, Branch 2].*

Staff did believe however that a certain amount of additional work was necessary and required. By putting in the required personal effort there would be a favourable outcome in the longer term. There were, however, limits to the period over which the extra effort could be sustained.

*I think as well there was a genuine enthusiasm there that they didn't want to fall out with their colleagues early on and that they would all knuckle down and get together and it was only a couple of weeks and then everything would be sorted but as time has gone on now that hasn't happened (Manager Retail, Branch 1).*

*The fact that I suppose that we had to come in and learn so much we knew we'd have to make a bigger effort but now it's kind of beginning to come around now they have started learning our products (Assistant Manager Capital, Branch 1).*

The effect of extended levels of personal investments however was very evident in the Branch 2 study where the level of integration was lowest of the three studies. The branch experienced significant levels of stress and sick leave and was experiencing a low level of morale.

*I would think that while some of the sick leave was genuine, more of it was probably most definitely probably stress-related and just needed a day off, you know. ...People are no longer happy coming in here: you know I'd say there is not a person in this building that would look forward to coming in to work in the morning and that is not good enough because I mean an unhappy staff member is, I would think, is an unproductive staff (Assistant Manager Capital, Branch 2).*

Similar issues on poor customer support and challenges to the morale of staff were also evident in the other branches but not as significant as in Branch 2. The feelings were summed up effectively by one quote from the Assistant Manager of Retail Branch 3 who stated as a closing comment “*Yea, it's just you have to battle on, ... battle on ....and head up ... and laugh a lot.*”

Personal investment creates a potential boundary by causing confusion between commitment to work and commitment to self. The perceived relationship that balances work commitment and individual time established in the pre-merger roles becomes dislodged and individuals become confused as to what is an acceptable investment of their time and effort in creating a new entity. There was an expectation for similar commitments to be evident from the merging partner.



The level of personal commitment an individual was willing to invest in creating a new group was high within the study but this waned after a period of time and particularly when there was a lack of success in achieving an acceptable relationship between the individual and their work commitment or there was a perception of a lack of commitment of others.

### *5.6.2 Work Processes*

Work processes are the ways in which the tasks and responsibilities of the groups are discharged. Work processes are different from job description in that the latter bounds what must be done while the former bounds how it must be done. A key element of the work process boundary was the manner in which it related the individual or group to the task. Individuals or groups have defined ways of tackling an activity and a number of clear differences emerged in the data as to how work process differences, even within similar tasks, can be present. Coding for this category was identified by references to actions concerning work processes, work activities or concepts that identify the importance of an activity performed in the branch.

There are a number of specific examples of how work processes created the potential for boundaries to emerge. Firstly there was the issue of targets and how they were established in each branch. To the Capital staff targets were based on volume while in Retail it was based on overall branch profitability. The difference is a direct result of the type of business, long-term lending versus personal banking rather than anything to do with the targets per se but it did lead

Retail to think that Capital did not understand profitability and for Capital to think Retail could not sell effectively.

*Well obviously their targets would have been slightly different than the way we'd be used to, like we'd be running our target on volume as regards they run on profit, how profitable the branch is. We're, our kind of targets are more or less based on the volume targets we had to achieve because once you've hit the volumes you know you're on a big profit (Assistant Manager Capital, Branch 2).*

*The focus of selling is a change of culture in the sense that we would always have had budgets and targets in Retail but they would have been reported on far less....the focus has shifted from service to sales (Manager Retail, Branch 3).*

Strongly linked to the differences in targets is the difference in approach to achieving these targets. Retail was viewed as service orientated while Capital was seen as sales-driven. The perception of difference appeared more evident among the Retail informants who experienced the greatest level of change in adapting to the new work practices.

*They're (Capital) very sales-focused, their training was all geared around it and so that you can see it they've lived with that. ....I've been on courses now, sales courses and would be amazed at how focused their staff are in comparison to our staff. You know in the sales area they're just, they're driven by that. Now I have to say it very probably has something to do with that they're very much rewarded for their sales but I have to say they're very very committed. Just listening to the sales pitch they are very sales-minded (Staff Retail, Branch 2).*

The perceived effect of this focus on sales was a negative impact on the customer and a sense of confusion on the part of the staff in how they should approach a given issue.

*Yea it was like heresy [bad customer service], you look after your customer and that was it. You get no thanks from this branch anyway, for say, going up against a customer. The customer was always right, within reason like, .... The difference with the Capital staff I would suppose is that there is that little, these are a list of what we are working and they were very rigid (Assistant Manager Retail, Branch 3).*

*Even the other day the assistant manager came up and he was doing a [long-term lending] application because they are using our system so he*



*was there trying to use our system and I sat in on the interview with him and he wanted to give the approval there and then whereas we are much more strict and we go through the motions and we look at the application (Staff Capital, Branch 2).*

Another impact of the sales versus service issue was the importance of different activities and tasks. Capital emphasised the sales interface with the client using the contact to sell. In contrast Retail focused on the client contact as an administrative task to be completed quickly for the customer. Retail supported the customer through activities such as queue handling. This was evident in the relative importance each group placed on certain tasks. To Capital the cashier's role for instance was *'just above washing the toilets, the worst job you could have'* (Manager, Retail Branch 3) while to Retail it was a senior job. Structures within the two head office organisations also supported the differences in sales versus service orientation with Capital having centralised administration (frees the branch to sell) while Retail had a decentralised administration system (locates records and information at the local level). Record keeping at the branch level impinged on the Capital way and was seen by many informants as backward and restrictive.

*The one big thing I have to say about Retail is they are very paper-orientated. Capital wasn't. Filing .... dirty word ..... but I know there are plans that they will go down the Capital way, which is great. We'll just shove the filing into an envelope, send it up to Dublin and let someone else up there do it, which is great (Assistant Manager Capital, Branch 1).*

A further impact was that staff gravitated toward the jobs they had done in the previous branch. Two issues account for this tendency. Firstly the staff focused on both jobs and behaviours with which they were comfortable and secondly the pressure of work on the branch placed the most experienced person in the role to complete the task. Some staff however felt this was a reduction in the potential

for personal advancement as they were not receiving a rounded development particularly given the changes in perception of task importance.

*.....since the merger really everyone has kind of kept to what they know best so that would be the Retail staff doing what they know and the Capital staff doing what they knew (Assistant Manager Retail, Branch 2).*

Work processes create confusion over how the tasks should be performed to meet the requirement of the new work context. Tasks that appear similar to past activities (i.e. job description similarities such as providing customer service) may need different behavioural activities or work relationships to adequately satisfy new job descriptions. This boundary is likely to create confusion over how the task should be performed and how the values of activities or behaviours relate to the new job description.

### *5.6.3 Team Behaviour*

Team behaviour relates to the nature of the team relationships that exists in the branch and the potential problems in carrying that relationship forward into the new branch. This behavioural boundary is clearly related to the physical boundary 'colleagues' but again, similar to the work process – job description boundaries link, the physical boundary defines the membership limits of the team while the behavioural boundary bounds the expectations of behaviour within that team (the difference between being and doing). Team behaviour was coded through references to team interactions, participation, personalities of team members and relationship characteristics such as openness, flexibility or friendliness.



A strong theme that emerged in the coding was the importance of being a ‘team player’ and making an appropriate contribution to the group. Differences, as noted before, could also stem from the sales-service orientation of the groups where definitions of team cohesiveness may represent different behaviour routines (i.e. supportive versus competitive).

*Like I said it's a very open branch and I think everyone in here gets on well with each other which I think is important especially in a small branch, even if there is 20 of us here which could be considered a big branch- it is a must that everyone pulls together in the same direction (Staff Capital, Branch 3).*

*We were a friendly place and we all got on well and you know we'd go for a pint on a Friday evening or whatever and what you need to know you know. You can't come like they can come and talk to anybody like we're not devils with horns hanging out of heads or anything like that. People seemed to get on well when they came in here (Staff Capital, Branch 2).*

A second theme related to the knowledge that team members had about the others in the branch and the closeness of the relationship as a result.

*We had a fairly considerable number of people here, yea, back to the former days you knew everybody, [The manager] can take that back further when they absolutely knew everybody because it was all in the one place. Yes there was a certain closeness, I wouldn't say everyone was walking around arm-in-arm meeting continuously, but there .. everything was smaller and you knew more people (Assistant Manager Retail, Branch 3).*

The impact of this boundary was to create a sense of loss and confusion among staff as to how they should relate to the expanded team and a sense of fear that the team interaction might disintegrate, with reports of staff being “wary of one another” (Assistant Manager Capital, Branch 1) or that “a bad attitude among the new expanded team would affect morale” (Assistant Manager Retail, Branch 2). There appeared a clear understanding that “compromises needed to be made” (Assistant Manager Capital, Branch 2).

*We're going to lose that personal touch, are we going to lose that personal, like how are you today and how did you enjoy the weekend. Is that going to go because there is so many staff here now you could spend the whole morning or afternoon finding out how their weekend was. Do you know what I mean. I'd hate to lose the way of people get on very well and you know everybody knows, well they don't know everything, but like there is a personal interest there you know (Staff Capital, Branch 2).*

*There was a lot of toing and froing. Sure people didn't really know each other and they were tippy-toeing around each other, everyone was as nice as pie (Assistant Manager Retail, Branch 3).*

The expansion of the team means that staff must develop new working relationships with additional staff members. Changes to the size of the branch (number of colleagues) means that new intra-team relationships and responsibilities must develop. This creates confusion over how existing behaviour routines need to change and how different sets of team interactions (i.e. supportive v competitive) are appropriate as the groups become exposed to new behaviours and as a new social order forms. The new team must understand the link between the social interactions of people and the activities of the group and come to agree a new set of behaviours if boundary conflicts are to be avoided.

#### *5.6.4 Customer Service*

The final behavioural boundary identified in the data emerged from the relationship the staff had with the customer or client of the branch. Each branch had different behavioural expectations of what constituted effective customer service. This was identified through references to the interactions between staff and customers and the relationship that was built and managed between staff and customers. Interaction included the speed of response to customers, the manner in which selling took place (i.e immediate consumption of a product versus



longer-term consumption) and the interface between the customer and the branch, (i.e. in loan applications or branch queues).

There were four interrelated issues for customer services boundaries, all of which relate to the relationship with the customer. Firstly both organisations espoused a strong customer focus and a willingness to do whatever the customer required.

*We've always you know, we've gone the extra mile in most cases with clients to kind of get the deal or to keep them happy or you know we're kind of we're kind of a keep them happy at all costs (Assistant Manager Retail, Branch 2).*

*If a customer asks you to turn around and touch the back of your toes that's it, you do it and there is no two ways about it you know (Assistant Manager Capital, Branch 2).*

*Our two customer focuses would have been very similar: there was a very strong focus on looking after the customer, customer care, so I think when you marry both of those together and the strength of both individual organisations you know we weren't moving too far off centre of each organisation (Manager Retail, Branch 1).*

Notwithstanding the apparently consistent focus on customer service and the need to deliver to the customer there was a strong bi-directional negative impression of the capacity of the merging partner to meet the same level of customer service. Both organisations felt the other could not deliver service to the same level as them.

*But why is there four complaints coming in, you know serious complaints whereby people really didn't... it just kind of shows to me that the staff members don't give a toss really whether the account is kept, lost or look if you don't like it go. And that was it. it was handled very bad, really they couldn't care less, you know (Assistant Manager Retail, Branch 2).*

*There was a lot of effort put in to striving to meet customer satisfaction. Especially with our branch 'cos we were so new we really wanted to get people in, get people interested so we were very much customer-focused .. ....well basically it takes a lot longer to get things done here there's more paper work (Staff Capital, Branch 1).*

The second difference occurred in the approach to sales and service. Retail's focus was on servicing the customer where the customer needs tended to be of an ongoing daily nature, making lodgements or withdrawals, managing a current account or short-term lending, while in Capital the customer had more complex demands i.e. long-term lending with many different product types and ancillary products available. In this respect Capital had a greater opportunity to sell products to a customer, for example life assurance, house insurance, investments and so on during an encounter with the customer. As a result Capital had a more sales-focused side to customer service and defined customer service in terms of delivering the right product. In contrast Retail serviced a customer who knew exactly what they wanted. Speed in delivery was therefore important and customer service was accordingly focused on resolving the customer request quickly and in the shortest, most pleasant, manner.

*I suppose our culture would have been different where somebody was taking out [long-term lending] and I know it's a huge investment as such and people are trying to cut as much costs as they can at the time and often we could offer, you could offer them the lowest life cover if you like (Assistant Manager Retail, Branch 1).*

*Next door [the capital branch] never have anybody in the door like they were always very very quiet and they were saying they got things done for the customer straight away whereas now they could be waiting and waiting or it could be put to the bottom of the pile and it will get forgotten about or it's like whoever's looking after it won't get to it for a few days or a few weeks (Staff Retail, Branch 1).*

Linked to service levels, the third example of the different nature of customer service arose in the attitude to queue management. The nature of the two task environments created two very different customer-flow demands. Retail, in particular had large volumes of customers frequenting the branch and conducting their business over the counter. This obviously reflected the nature of the customer's shorter-term requirements. Customer service was therefore defined in



terms of the ability to keep the customer's time in the branch to a minimum and to maintain a fast moving queue. In contrast Capital's focus on longer-term discussions with the customer resulted in a smaller amount of higher-value traffic in the branch.

*I'm hoping that people will have enough skill to keep the queue moving to open that new account to I'm hoping that we're not going to be found wanting up the road be it the Retail person not knowing how to do the Capital things or vice versa (Assistant Manager Retail, Branch 2).*

*Queuing, people are maybe former Capital people mightn't be used to 10 or 12 people in front of them in a queue (Assistant Manager Retail, Branch 2).*

The final aspect of customer service that had the potential to create a boundary problem was the perceived relationship between the branch and the customer.

There were frequent references to the 'family' nature of the branch and this included the relationship to the customer. The relationship with the customer was seen as 'very good' and 'personal.'

*The customers knew everybody, we knew the customers but I suppose it was easy because we were a new branch and it was easy for us to get to know our clientele as well (Assistant Manager Capital, Branch 1).*

*The staff are more from the area than was originally in the other banks. It was localized. People knew you. .... and from that point of view it was all personal really and you could give it the personal service (Assistant Manager Retail, Branch 1).*

*Our customers tell us that we are the most friendly branch probably in town and I think it's because we've gone out of our way to personalise things, in other words we know most of our customers by first name and they would know us and that would be fairly different. Banking generally wouldn't be as friendly as that but I think we have a very good portrait (Manager Retail, Branch 2).*

The boundary problem in this particular instance was not a problem with differences in the two organisations however but rather the fear that arose from the creation of a larger entity that would disrupt the relationship between the branch and the customer.

*They [the customers] don't know them any more. There is no familiar people at the desk, service levels are way down what are ye doing you know some serious amount of complaints (Assistant Manager Retail, Branch 2).*

*I think because you merge with a bigger entity you lose a bit of that personal touch (Assistant Manager Capital, Branch 1).*

The relationship to the customer creates a potential boundary between the two combining units through the confusion caused in translating the products and procedures into a meaningful way of servicing differing customer requirements. A tendency to assume the relationship to the customer has remained the same was evident and this created a disconnect between actual and perceived requirements.

## **5.7 Cognitive Boundaries**

Cognitive boundaries are differences in the way people think about and make sense of the world around them. The distinguishing factor in cognitive boundaries is the value assigned by the individual to a component of their organisational environment. Cognitive boundaries relate to 'thinking and feeling' rather than being (physical boundaries) or doing (behavioural boundaries). Two types of cognitive boundary were identified, values assigned to the work practices, which was termed Work Beliefs and value of the association with the work group or organisation which has been termed Belonging. Data on the amount of coding in respect of each dimension is presented in Table 5.3.



Table 5.3: Cognitive boundaries in the financial study

Boundary Type	Overall Totals (n = 15)		Capital (n = 6)		Retail Co. (n = 9)	
	Informants Referencing	Passages Coded	Informants Referencing	Passages Coded	Informants Referencing	Passages Coded
Work Beliefs	14	44	5	21	9	23
Belonging	12	51	5	24	7	27

5.7.1 Work Beliefs

As well as having physical and relationship dimensions, the work performed also has a cognitive dimension. Differences existed between the two groups on the definition of the work itself and the relative value of the component tasks, for example the importance of back-room administration versus front-line selling. There were strong and divergent feelings about aspects of work including the interpretation of ‘being busy,’ of what products should be sold, how they should be sold and finally of the role of the people within the branch which included staff promotion and advancement criteria.

Perhaps the strongest indicator of a cognitive boundary arose in the definition of what being busy actually meant. The shorter customer service cycle in Retail manifested itself in multiple customer interactions throughout the day. In Capital the focus on large volume items and multiple cross selling as part of one transaction created a longer customer interaction cycle with less immediate customer demands. As a result, Retail had a significantly larger number of daily customer visits than Capital. The less frequent customer contact in Capital was often translated in the eyes of the Retail as meaning that Capital was not busy. In contrast Capital considered Retail as not been busy given their target levels of lending which were substantially lower in volume terms. Capital felt that Retail

would get a shock when they were asked to reach the volume that Capital was achieving.

*They are going to feel it even worse, if you know what I mean, because they're not as busy. You could walk into their branch since the merger and they're all sitting there. There are no customers in the branch, their phones are not hopping so they have no idea of queues even. We have a queue here practically out the door all day long and you're going going going (Staff Retail, Branch 2).*

*They came from a totally different environment, there was maybe only one person in a queue down there and there was plenty of time for them to do their work. You certainly wouldn't have that workload here (Assistant Manager Retail, Branch 3).*

*My impression is that they don't realise how busy we actually are... but I don't think that they realise how busy our back office stuff is like compared to theirs. They see the queue at the door thinking this is great business we are really busy but it is the transactions that are going through that make them look busy whereas our back office our [long-term lending] is extremely extremely busy ..... So in that respect I think it is going to be a shock to them when they come up here and say Jesus they are busy in here actually. aren't they? (Staff Capital, Branch 2).*

*For instance to me now coming in to the Retail scenario you see queues at the door. I am not interested in queues at the door. What are they doing? Coin business, you won't have profitable back business at the end of the day because you're employing one person to stand there and serve the business customer and they mightn't even be business customers [of this branch] (Assistant Manager Capital, Branch 1).*

There was also evidence that the two organisations thought differently about the work-flow of the organisation. For instance there were differently desired levels of flexibility or rigidity, there were differences in the perceived proximity to the customer and there were differences in the perception of promotion and reward practices.

*We would have had different ways of looking at things, say, doing business or doing loans we might have been a bit more flexible. Whereas Retail, very very rigid. Everything came down to, is their account good? If their accounts weren't good, the business wasn't worth doing, whereas I felt coming from Capital, that you had to give people a chance. Everyone has ups and downs and they need to be taken into account. I felt they were very rigid in that regard. Very rigid in paperwork,*



*documentation. Totally unnecessary, more paper now than I ever worked with in my life, and it's supposed to be an age of computers (Staff Capital, Branch 3).*

*Personally I think the skill levels were far lower [in Capital] because the system made it far lower, the system didn't make you question, the system said there are the boxes, you fill up the boxes and you let someone else make the decision, you don't make the decision. Well if the boxes are filled up, you're covered, it doesn't matter then (Manager Retail, Branch 3).*

*Maybe, we get too personally involved at times in decision making, you know. We find it very hard to say no or whatever, whereby maybe they are a bit colder about the whole thing which would be better as well even from a personal point of view. If you're going to get too involved in something it's very hard to go back and say no we can't do the deal or whereas maybe another guy that trained in a different way says ah f\*\*\* sorry can't do the deal, good luck, cheers then, you know, doesn't phase him at all literally you know. Where as we go all Jesus I'm sorry I wish I could have done it and you know it's just we've had too different, we've been trained differently, and so I mean I'm not saying that theirs is bad or whatever it's good from the point of view from a conscious point of view they are probably had an easier life than any we've had (Assistant Manager Retail, Branch 2).*

The work-flow values also manifested differences in perceptions about what range and types of products should be offered and how it was appropriate to sell specific types of products.

*I remember being at meetings not so long ago, ..., and we were talking about [a new product launch], the issue of DD<sup>32</sup> came up... And this ex-Capital person said, what! I would be insulted if someone asked me to transfer my current account, if I had gone in for a mortgage. What are we about here? I just thought that it was a fierce clash, I thought that is what we are about now we wanted the current account. But she was technically against it. I remember coming back and saying it to the Manager and we just couldn't get over the remark (Assistant Manager Retail, Branch 3).*

*The emphasis is all on the business customer and I'd like to know how much exactly is the business customer worth, like is it worth all that hassle that they were going on about like so much background work went on, you know that kind of way and I suppose it's all part of the learning process and we have enough to learn as it is like I suppose like we just*

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<sup>32</sup> Direct Debits – the campaign was primarily aimed at selling mortgages but also designed to get new current accounts signed up by the customer and branches were being asked to request that DDs came out of a Capital and Retail current account.

*don't know what happens with that end of business (Staff Capital, Branch 2).*

The final example of a work belief boundary is the relationship of work to time. There were clearly different values on how time was best spent servicing or selling to the customer or what a reasonable time for responding to customers was. These time differences related again to the context of the two organisations' prime activities (short- or long-term lending) and the time orientations that underpinned these activities. Retail defined effective working and good customer service in terms of getting the customer serviced as quickly as possible and spending the minimum time with the customer. This is in contrast to the idea of identifying and diagnosing customer requirements and selling the maximum range of products within an interaction that permeated Capital. Retail minimised the time with each customer (keep the queue moving) and Capital maximised the time available to sell to the customer.

*The Retail people who were on the course with me felt it [work process for long-term product] was cumbersome, it was sort of elongated it, dragged everything out that you could, you know, instead of taking an hour with a person you could at least cut it .. by a third or even by a half (Assistant Manager Retail, Branch 1).*

*Yeah maybe because of the products they did like mortgages, application will not be done overnight it could maybe take a month, six weeks, whatever, so people will say, look I'll come back to you tomorrow. If you are dealing with current account stuff you could be dealing with something that it will hit the account tonight and a decision has to be made here and now (Assistant Manager Retail, Branch 2).*

Work belief boundaries impact on staff by challenging their understanding of work. Previously taken for granted assumptions, such as being busy, are challenged and a tension arises as the need to understand a new concept of work is required. This boundary also marked a shift in emphasis from a discourse of comparison usually expressed in terms of 'ours is better than yours' which



permeated physical and behavioural boundaries, to a discourse of lack of capability expressed in terms of ‘they don’t know how to do it properly.’ As a result of this where boundary conflicts do occur, then the conflict is likely to be deep-seated and based on a lack of understanding. This occurred to some extent in Branch 2 where morale was low and inter-group conflict was emerging from perceived inability of some staff to rise to the challenges of the new branch. Tensions arising from work belief boundaries will be based on a lack of understanding about the alternative work content and disconnects between the underlying assumptions made by the designers of those work contexts. These disconnects may arise from structural design (administration in branch versus centrally), from work-flow needs (short- versus long-term products), or from the measurements adopted (throughput versus sales volume). Conflicts emerging from work requirement boundaries were expressed in terms of broader cognitive definitions, for instance, being busy, flexible, or responsive.

### *5.7.2 Belonging*

Belonging captures the concepts of identify and membership. Groups assign rights to members but also assign obligations based on adherence to group cultural values and beliefs. Where membership of a group is of a permanent or long-term nature these values often become tacit and operate at a sub-consciousness level. There was evidence in the cases of strong affinity with the previous organisation, both at the corporate level and the local level. A strong sense of membership and identity emerged with the groups and these translated into values about what membership meant. The belonging boundary was

identified in informant's transcripts through references to membership or identity of groups and through emotional or value statements about the groups.

A theme that emerged repeatedly in the coding was that aspects of the previous group were unique. References to the sense of family, sense of pride, sense of unity and loyalty and reputation were commonplace. Uniqueness was ascribed both to the organisation as a whole and the specific branch in which the informant previously worked. Indeed the characteristics of the previous work branch appeared to be imputed to the organisation as a whole unless there was clear evidence of the contrary, in which case the previous branch became unique in its own right. Belonging is an important cognitive boundary as it defines the value set the individual accepts as part of the group membership and culturally acceptable norms.

The conceptualisation of the group as a 'family' was commonplace in both organisations. Family represented the sense of community and group identity. There were strong emotive and value associations with this metaphor, specifically the sense of loyalty and unity.

*..that sense of family or that sense of comrade or that sense of oneness that we had in Retail (Manager Retail, Branch 1).*

*I felt that, how would you put it, there was a family feeling inside, everyone got on well ahh... it was a very enjoyable place to work, I must admit. ... it was a very enjoyable place to work (Staff Capital, Branch 3).*

*When [name] was our manager and [name] was our assistant manager we were all one little happy family (Staff Capital, Branch 2).*

*The culture has always been one of a friendly family-type culture if you can imagine that more associated with smaller organisations than with the big multinational .... as I said as we got bigger and as the merger was created that just diluted it. Now I would say it's gone, that family that*



*isn't there anymore, you will get it at local level albeit a to a minor extent (Manager Retail, Branch 1).*

A second aspect of uniqueness was the pride felt by the staff in relation to the customer's perception of the service provided and the sense of reputation in the community. This presented a sense of identity to the staff and a belief in what they were doing. There is a strong sense of emotional attachment to the 'old ways' even expressed in terms of 'loving it.'

*Course It's glossy recall at this stage but I loved Retail, I loved what we were about. I was very proud to work for Retail. We had a really good reputation. And people would say that you were the best bank in town.....so I was really, really proud to work for them. They were a really good [organisation]. (Assistant Manager Retail, Branch 3).*

*We were very proud of our bank .. we were one of the top branches in the country for [long-term lending]. (Assistant Manager Capital, Branch 1).*

An outcome of this boundary was the sense that the staff member did not yet belong in the new organisation with a concomitant loss in the sense of loyalty and pride in Capital and Retail.

*Yea..... without a doubt..... I think our pride is gone. I really do at the moment, I think it's gone (Assistant Manager Retail, Branch 3).*

*People just don't have the same loyalty and if I regret the loss of anything I regret the loss of that, it's unfortunate but that's I think maybe it's symptomatic of the type of company that we are now or is it symptomatic of just being just a much larger company? I don't know (Manager Retail, Branch 2).*

This was set against a backdrop however of a potential positive image moving forward.

*The future is very exciting for this organisation and it's nice as well to be in a position where we've always kind of I won't say felt inferior to the other banks, that wouldn't be the case, but we've always felt on a scale below where they were. Now there is no disparity there whatsoever. We feel much much more comfortable taking them head on you know and we have the resources now to do that (Manager Retail, Branch 1).*

*I suppose you hope in yourself that you'll bring a little individual flair to it and that hopefully in a few years time you'll be able to be proud and*

*say well look I work in Capital and Retail and look how far we've come, I think that will happen. We'll have to get through a lot of teething problems probably between now and then. I think it will be a force to be reckoned with eventually because we have to be or the shareholders will fire us all (Assistant Manager Capital, Branch 1).*

*I think that Capital and Retail has a lot of very positive things going for it, its size, its power in the market in terms of its advertising spend, the presence we have in the market is a very positive force. I think we have a lot of channels we didn't have before (Manager Retail, Branch 3).*

Belonging as a potential boundary challenged the sense of identity of the staff, requiring them to let go of past identities and subscribe to a new group and organisational identity. Tensions were created because of the challenge to the identity and the sense of group unity. Boundary conflict arising from belonging was expressed in terms of detaching from the identity and purpose of the new organisation and disagreement with the concomitant value set. The sense of a positive new order mitigated the disconnection.

### 5.8 Conclusion

This chapter has presented the data from the financial services studies. The study uses the boundary framework to identify the boundaries that exist for physical, behavioural and cognitive categories of boundaries. Table 5.4 lists these boundaries.

Table 5.4 Boundary types for each boundary category

Physical Boundaries	Behavioural Boundaries	Cognitive Boundaries
Job description	Personal Investment	Work Beliefs
Product set	Work Processes	Belonging
Location	Team Behaviour	
Colleagues	Customer Service	
Owners		
IT system		
Branch manager		



The findings in this chapter gives strong support to the framework established in table 2.4 and the ability to categorize boundaries along physical, behavioural and cognitive lines. Furthermore, the boundaries identified create unique tensions for the combining staff. These tensions will be explored further in the next chapter which discusses these findings with the aim of developing the boundary framework identified in table 2.4.

## **6 Discussion on the Financial Services Study**

### **6.1 Introduction**

This chapter addresses the second pillar of the research design. It extends the findings of the previous chapter, which identifies the boundaries that exist within each boundary category, to develop theoretical insights into how management interventions impact on these boundaries. This will allow an understanding of boundary change to be developed. The previous chapter identified the tensions that each boundary created and this chapter will explore those tensions in greater detail uncovering the relationship between the tensions and the impacts of actions on boundary change. The boundary framework described in chapter 2 (table 2.4) will be applied to understand how the three types of interventions, contact and awareness building, training and development and vision creation impact on each boundary category. The chapter ends with a new framework for the management of boundaries that will be used in the hospital action research study.

### **6.2 Developing Theory on Boundaries in M&As**

The previous chapter outlined the types of boundaries that exist within the financial study. This section sets out to explore the second and third aims of the study, notably assessing the potential impact of these boundaries on the amalgamation, and to theorise how the different boundary types have latent potential to hinder integration in an amalgamation. Drawing on the data from the financial study the section will then address how this latent potential was



managed in the study and to build from this an action model for managing boundaries in M&As.

### **6.3 Boundaries as Creators of Tensions**

Chapter 2 demonstrated that boundaries created tensions when boundary crossing must occur. A similar tension was evident in the study. The boundaries in the study created a level of tension for staff that had to be overcome but each of the three categories of boundary exerts different types of tensions on organisational members. Physical boundaries created a tension due to the unfamiliar surroundings created from the new staff, changing offices, extended products or physical changes in the branch. Behavioural boundaries created tensions in having to redefine the relationships between staff, their colleagues and their stakeholders, while cognitive boundaries created emotional tensions from the changes in values systems within the new organisation. These tensions served a number of functions with both positive and negative effect. The tensions served to disrupt existing social orders, whether that is the physical environment, the behavioural routines or cognitive schema and in that respect created uncertainty and stress for individuals. The tensions however also marked the shift from one social order to another and once the tension had been resolved a new acceptable social order emerged. In that respect the tensions mark a transition which in the successful branches had occurred and in the less successful branches had not occurred.

### *6.3.1 Managing Physical Boundaries and Surroundings Tension*

Physical boundaries occur from differences in the physical environment of organisational members. The boundaries falling into this category represent the physical component parts of the work environment from the work structures through to the products, people, tools and other important symbols that represent key artefacts of work. Where changes were perceived to occur to the physical surroundings of the staff then the staff appeared to feel a sense of 'loss of familiarity' and a need to get comfortable with the new surroundings. This was evident within the study with examples such as the sense of uneasiness about the layout of buildings, the tension of getting to know more staff because of the increase in staff numbers or the sense of starting a new job because of the need to learn a new IT system. The relationship of each boundary type to the creation of a type of surroundings tension is outlined in table 6.1. All of these tensions were closely related to the surroundings of the staff and the move from a familiar surrounding to a changed surrounding.

These tensions create a sense of the unfamiliar requiring the staff to accustom itself to the new surroundings. Each boundary identified created a specific type of unfamiliar effect. Job description caused unfamiliarity with structures such as working times and terms of employment. Product sets created new and unfamiliar products that the staff had to understand. Location changes created a new physical environment and unfamiliarity in how to navigate and get accustomed to the new premises. Colleagues increased in number arising from an influx of new staff and this led to unfamiliar people in the branch. The change in owners created unfamiliar demands and targets for the staff to achieve. IT system



changes created new tools for the staff to assimilate while the appointment of the new branch manager presented staff with an unfamiliar direction in terms of branch values and power.

Table 6.1: Types of and tensions created by physical boundaries

Type of Boundary	Cause of Boundary	Tension Created by Boundary	Example from Study
Job description	Differences in the context of work i.e. terms and conditions	<i>Unfamiliar Structures:</i> What are the structures to which staff are working	References to the rota-day versus overtime for working late on Thursday.
Product Set	Differences in the range of product and services offered by the firms	<i>Unfamiliar Products:</i> Understanding the new products	References to the 'skills gap' in product knowledge between the two organisations
Location	New premises or altered premises (comparison of old versus new)	<i>Unfamiliar Location:</i> New or different building	References to not knowing the layout of the building or the unsuitability of the building
Colleagues	Alteration to the existing team structure through the addition of new members	<i>Unfamiliar People:</i> Need to get to know new people	References to the concerns of the team size and getting to know the new members.
Owners	New ownership structure	<i>Unfamiliar Demands:</i> what is required by new owners	References to shareholder objectives
IT System	Selection of one IT system over other	<i>Unfamiliar Tools:</i> Need to get to know how systems operate	References to difficulty in adopting to new IT systems
Branch Manager	New manager, which represents loss of gatekeeper and symbol of leadership and power for one group.	<i>Unfamiliar Direction:</i> What does the new manager value and how do they operate within the new power structure	References to personal loss over the departure of the manager and to the need to get to know how the new manager operates

The impact of the changes in the familiarity of the tangible aspects of the work environment results in the comfort of the traditional surroundings being lost and a sense of disorientation occurring. Boundary issues likely to arise as a result of the unfamiliar surroundings will be attempts at reasserting familiar surroundings. Preferences over product sets, IT systems or buildings may emerge and will typically take the form of a debate about one set of surroundings being better than another. Such conflicts concern disagreements *about* physical aspects of the work.

Physical boundaries have the potential to create problems for integration if the boundary disputes result in one or other group disengaging from the change in the surroundings and rejecting the new. This could occur for instance if one side fails to accept new work practices, fails to change to a new IT system or fails to accept the new directions set by the leader. The effect of these problems is likely to result in the staff disengaging from a particular boundary issue. A physical boundary dispute is however likely to be an isolated event as it concerns a particular tangible aspect of the surroundings that can be resolved by the reduction or elimination of the unfamiliarity associated with that aspect.

Resolving physical boundary problems or eliminating the potential for them to emerge involves management of the surroundings in the amalgamation.

Specifically, if the potential for physical boundaries to create boundary issues arises from the need to reassert a familiar environment for staff then management can reduce the potential conflicts by making the surroundings more familiar and more accessible to staff. There were many examples in the case of how the branches achieved this effectively. There were a number of centrally managed initiatives such as staff-swapping that engaged each set of staff in seeing how the other branch operated and which allowed staff to engage with one another.

Integration meetings gave amalgamating branches an opportunity to come together to prepare and plan the amalgamation. There were also initiatives at the local level such as social events and informal meetings. Comparing the Branch 2 and Branch 1 amalgamations is instructive. The latter branch invested heavily in pre-amalgamation contact and awareness building ensuring that *'on the very first day at least our heads were right'* (Manager Retail Branch 1); in contrast far less



contact and awareness was evident in Branch 2 which resulted in '*issues not being dealt with*' (Assistant Manager Retail Branch 2). Branch 2 had far greater stress and uncertainty post-merger evidenced by the level of sick leave, staff disengagement and a lower level of effectiveness post-merger.

### 6.3.2 *Managing Behavioural Boundaries and Interaction Tension*

Behavioural boundaries occur from expectations about the relationships in the work environment, notably through customer interaction, team interaction, work processes and the extent to which a staff member is willing to commit themselves to the work. These boundaries emerge from the different actions that form the basis of group interactions. They set the norms of behaviour for the group as a whole. When behavioural boundaries come into contact confusion arises as to how tasks should be completed, with a corresponding mismatch between the action and the needs of the action recipient. A clear example of this in the case data was the mismatch in dealing with the immediate requirement of daily banking for the Retail customer and the longer-term borrowing needs of the Capital customer. Staff was expected to interact with customers in a new manner that was at odds with their previous approach. Interactions appeared to meet the perceived needs of the customer but failed to meet their actual needs. This was particularly evident in the sales versus service issue. Retail staff kept queues moving rather than treating each interaction as a sales opportunity. This boundary creates a tension around interactions of people. The particular types of interaction tension for each of the potential boundaries within this category are identified in table 6.2.

Table 6.2: Types of and tensions created by behavioural boundaries

Type of Boundary	Cause of Boundary	Tension Created by Boundary	Example from Study
Personal Investment	Level of personal commitment that an individual is willing to invest in the work/group	<i>Commitment Confusion</i> Creating balance between self and work	Working ‘unrealistic’ times and working extra hours to facilitate group cohesion
Work Processes	Differences in how work is performed and tasks completed	<i>Task Confusion</i> Matching tasks and the way they are performed to meet new job description	Servicing versus selling to the customer
Team Behaviour	Expectations of behaviour within the team	<i>Social Confusion</i> Operating in new emergent social order and determining the position within that social order	Importance of being a team player and the desire to have good social relations in the new branch notwithstanding ‘being wary’ of each other
Customer Service	Changing customer requirements and interactions	<i>Translation Confusion</i> Translating the products and procedures into meaningful customer interactions	The queue management emphasis in each organisation.

Behavioural boundaries create tensions that generate confusion over the expected behaviour of staff. This confusion occurs either for the individual who may become unsure (consciously or otherwise) of how they should behave in a given interaction or for a group’s expectation of how an individual should act in a particular situation. Each boundary creates a unique tension that generates confusion over a specific aspect of work relations. Personal investment boundaries create confusion over the commitment of the individual, work process boundaries create confusion over matching the tasks to the expected behaviour, team behaviour boundaries create confusion over the expected behaviour in the new social order and customer service boundaries create confusion over the translation of actions into meaningful customer interactions. Queue management provides the best illustration of this point. Retail staff considered queue management as a most critical part of operations and that the



primary focus should be spent on keeping the queue moving. Capital in contrast experienced the queue in quite a different way. It was not a major aspect of their business and represented a distraction to their lending orientation. The approach to queue management could not be readily reconciled with either group. In this respect behavioural boundaries have the potential to create conflict or boundary problems *with* the actions or behaviours of individuals. This is in contrast to physical boundaries that create problems about an issue.

The potential for behavioural boundaries to create problems will be highest when the behavioural differences go unchecked and individuals continue to operate under the behavioural norms applicable to their previous organisation. In such cases it might be expected that the differences in approaches will heighten the confusion between staff. For instance, a breakdown in the social process of interaction will result in a fragmentation of the team spirit and the formation of distinct groups which will interact with each other poorly. The case study did not demonstrate any significant boundary problems emerging over behavioural issues although the Branch 2 site did give some indications of the type of issues that might occur. In that study there was some dissent about the level of commitment of staff as well as problems with the effective handling of customer service issues. These were reasonably minor. In general the behavioural boundaries merged effectively within the case units. This perhaps can be put down to the very effective centrally managed programmes of training, development and support that the organisation initiated. All staff received training in new systems, procedures and products. Supporting staff were seconded to branches for the first weeks of the amalgamation to assist staff and

to advise them based on previous experience. In addition at the local level staff exchanges and individual manager's initiatives in discussing the working and social relations with new staff facilitated individual staff to link the new work surroundings to the necessary behavioural expectations, generating double-loop learning (as staff became more aware and reflective on what the changes meant) and hence to smooth the transition to the new structures.

Resolving or eliminating the potential of behavioural boundary problems is based on producing a mechanism for the resolution of the interaction tension that the boundary creates. Providing awareness of these new surroundings and relationships is insufficient, as this will only tackle the awareness of the new surroundings. In addition a new repertoire of behaviour responses is required and this can only occur when the staff are shown and trained effectively in the new requirements. There are four distinct aspects to this in the particular case and these relate to the four boundaries within the behaviour category:

1. Staff must be confident in their investment in the organisation by understanding the relationship of their inputs to the potential rewards they might receive either organisationally or socially (building motivation),
2. There must be clarity on the job description and how to deal effectively with the products or service (product training),
3. there must be a consistent expectation as to the role and performance of the team (team building and norm formation) and
4. there must be clear guidance as to service requirements (customer sales and service training).



Within the case both central and local management structures addressed these four issues and this may explain the effective behavioural integration that was achieved.

### *6.3.3 Managing Cognitive Boundaries and Affective Tension*

Cognitive boundaries arise from beliefs and values. They represent the potential for differences to arise from the underlying assumptions that individuals take for granted. The study uncovered two types of cognitive boundaries, work beliefs and belonging. These boundaries arise from a common set of values individuals assign to the work and the organisation and which creates a pre-defined schema for understanding the work and the individual's place within the work structure. For example the definition of work within Retail was the completion of transactions initiated by the customer while to Capital work entailed the initiation of sales by staff. While there is a behavioural focus to work practices there is also a significant cognitive effect that translates for each set of staff a value system that defines productive work. A cognitive boundary arises as staff rejects the underlying logic of the changes. This is evident in the study. The drive by the parent company to focus on a sales approach to customer service was in some cases seen in Retail as being inappropriate and inconsistent with their previous philosophy. Retail was not willing to '*flog products to the customer*' even if that is what the parent company required. The tension created from this type of boundary contact is affective in nature. It challenges the value and belief set of the staff and makes them question the link between why they are doing things and what they are doing.

The types of tensions created by cognitive boundaries are identified in table 6.3. Two types of challenges arise from the boundaries. Firstly there is a challenge to the sense of the change as individuals question whether an improvement has occurred and whether the values underpinning the activities are valid. This is clearly evident in Retail’s reluctance to accept a sales orientation, if it meant flogging goods to the customer. The underlying values embedded in the concept of customer care espoused by Retail were being challenged. The second challenge arises from the loss of identity felt by staff. Their old organisation is gone and they need to recreate an identity within the new organisation that accepts both them and their partner firm. Again this was very evident in the references to pride and the loss of pride resulting in the formation of a new organisation that failed to mirror the old organisation’s values and beliefs.

Table 6.3: Types of and tensions created by cognitive boundaries

Type of Boundary	Cause of Boundary	Tension Created by Boundary	Example from Study
Work Beliefs	Differences in the underlying logic of why the work is performed in a given manner	<i>Sense Challenge:</i> Understand the validity of the other’s way of conducting activities	The need to accept that ‘being busy’ included sales and service. Retail v Capital way.
Belonging	Importance of group membership and Identity	<i>Identity Challenge:</i> Motivation to feel part of the combined organisation/ let go of the old and accept the partner organisation	Sense of pride felt in the branch and organisation achievements

Problems that occur from cognitive boundary clashes are most likely to be severe. They will arise from the emotions and values individuals hold about the organisation and accordingly differences will be manifest in terms of rights and wrongs. These problems will be affective in nature and may emphasise feelings of trust, pride or justice. In contrast to physical boundaries, that will create



conflict about an issue, or behavioural boundaries, that will create a conflict with actions taken, cognitive boundaries will create conflict *because* of a change in values.

To manage cognitive boundaries either to resolve emerging conflict or to prevent conflict in the first instance, requires an attempt to resolve the challenges to sense-making and identity. Contact interventions and training interventions will bring to the fore the types of physical and behavioural differences that emerge in the amalgamation but will not specifically address the logic and understanding of staff. These activities may show what needs to be done but not necessarily why they should be done or indeed why the staff should feel a sense of belonging to the new organisation. The key activity in the reduction of cognitive boundaries in the study appeared to be the sense of vision created for the new organisation. The branch with the least level of integration (Branch 2) was focused very strongly on the daily operations and on short-term goals. In contrast the branches showing the greatest integration had clear images of the future, of the benefits the new group would have and how they would be better off as a result. Although in many instances there were problems to be resolved, the potential for the future was seen as a worthy cause for the suffering. Several activities build this vision. Again through the Head Office interventions, the level of information and communication coming from the integration unit and the variety of communication meetings present a vision of the company being a major force, a company to be proud of and a leader in its industry. At the local level the branch manager in both Branch 3 and Branch 1 spent considerable time talking about the future to staff and explaining to them the potential going forward. This was done

through the manager spending time with branch staff on a group and individual basis discussing the changes and explaining what they meant to staff individually and collectively. These managers met each staff member individually to discuss the future and their role within it. In both of these branches managers were seen to support team integration and foster discussions in an open manner. This gave a context for staff in which they could deal with the affective challenges and make sense more readily of the work changes facing them. It also served to bond the team under a common banner and create a more cohesive unit that aids identity formation.

#### **6.4 A Framework for Boundary Management**

Drawing together the tensions created by the different boundary types, the effects these tensions create and the manner in which they were managed allows a framework to be developed that explains the boundary behaviour in the study (based on table 2.4). It also allows the development of some theoretical insights on how interventions might influence the potential for a boundary to become salient. Three types of broad interventions have been identified, contact and awareness building, training and support, and vision building. Each one of these interventions has a distinct effect on a boundary category. Table 6.4 sets out examples of interventions and the corresponding impact on each boundary category. The tension created by each boundary type requires a specific type of intervention to reduce or eliminate that tension. For instance, building awareness of the products on offer by each branch will allow staff to understand the range of products and not to feel unfamiliarity in handling or discussing them. However, when it comes to interactions with customers, previous contact may



not assist staff in understanding the way in which they are expected to sell the products. In addition the awareness of the products does nothing to help in resolving the potential challenge to the staff’s value set on what types of products should or should not be sold. Similarly training the staff in sales or supporting them in their sales efforts will help resolve the confusion on how to interact but may not assist building familiarity with the products or in understanding potential shifts in value sets. Finally, broad approaches in building a vision will motivate potential changes in value sets and identity but fail to address either the new behaviours required or build familiarity in surroundings. It was noted in sections 2.9.1 to 2.9.3 that the interventions categories may have overlapping impacts, for instance training may require amalgamating staff to come into contact with each other and in this respect some actions may incorporate multiple interventions. However table 6.4 clearly shows that, within the financial study, interventions types had primary impacts in certain boundary categories.

Table 6.4: Examples of impacts of actions within boundary categories

Example from study	Physical Boundaries	Behavioural Boundaries	Cognitive Boundaries
<b>Contact and Awareness Building</b>  <i>Example: Pre-merger amalgamation meetings</i>	Staff aware of each other and physical boundaries are visible and can be consciously acted upon	Staff tippy-toeing around each other (Branch 1) because they are not sure how they must interact with new team members	Contact builds awareness of what each does (i.e. length of queues) but does not build understanding (i.e. concept of busy) (all branches)
<b>Training and Behaviour Support</b>  <i>Example: Sales support and training programme</i>	Link between new behaviour and new surroundings not always evident i.e. refusal to sign up current accounts (Branch 3) after loan-application training	<b>Training on sales techniques provides individual with new behaviour routines. Individual knows how to relate to customer</b>	Awareness of required behaviour but this may challenge the identity of individual. (i.e. refusal to ‘flog’ products to customers (branch 3)
<b>Building of a Vision</b>  <i>Example: Culture and Value programme from Head Office</i>	Primary concern at branch levels was managing new team and getting on with each other (branch 1) so corporate aims became secondary (i.e. actions often targeted against HO as a means of building branch unity)	Clarity on need to sell but unsure how (i.e. definition of flexibility on dealing with customer – Branch 2)	<b>Clear vision that the new organisation would be a force in banking and that they could now compete more effectively</b>

Table 6.5 relates the examples of boundary impacts into a theoretical framework for exploring boundary impacts. The table suggests that

1. positive impacts on boundary change are delivered from different intervention:
  - a. Contact and awareness building builds familiarity;
  - b. Training and behaviour support reduces confusion;
  - c. Building vision reduces the challenge to values.
2. the impact of each intervention type will vary across boundary categories and will be limited in some cases;
3. effective boundary management will require all three intervention types.

This framework explains why so many problems can occur within merger integration. All three intervention types must be present if all boundary categories are to be addressed. The limited impacts of interventions in some categories explain some of the problems often encountered in M&A integration. For instance, training and behaviour support might be expected to impact on all three categories, but the evidence within the case suggests that without the training being embedded within the physical daily activities a disconnect between the training and the implementation will occur. Similarly, the inherent values associated with task behaviour may not be engaged within a training session resulting in rejection of behaviour on ethical grounds. Again, it is important to note that the division of activities into these intervention types is simplistic as activities can often span more than one of the types, e.g. training might be focused on vision building. In that respect it is possibly more



sophisticated to consider intervention types as a seamless continuum of behaviour. Perhaps this is an avenue for future research.

Table 6.5: A Framework for boundary management linking tensions, boundaries and management interventions

	Physical Boundaries	Behavioural Boundaries	Cognitive Boundaries
Type of Tension created by Boundary	From Surroundings	From Interaction	From Affective attachments
Potential For Boundary Conflict where boundary becomes salient	Boundary arises <i>about</i> an issue due to ‘ <i>unfamiliarity</i> ’	Boundaries arise <i>with</i> an action that creates <i>confusion</i> over its appropriateness	Boundaries arise <i>because</i> of a <i>challenge</i> to the value set or identity
Effect of Management Interventions			
<i>Contact and Awareness Building</i>	Builds awareness and familiarity  <i>Positive Effect on Boundary</i>	Staff are aware of surroundings but confused on how to interact within the new surroundings  <i>Limited Effect on Boundary</i>	Staff are aware of surroundings but not how it relates to their values  <i>Limited Effect on Boundary</i>
<i>Training and Behaviour Support</i>	New repertoire of actions but unfamiliarity remains as to how they link to the surroundings  <i>Limited Effect on Boundary</i>	Builds repertoire of actions that can reduce confusion.  <i>Positive Effect on Boundary</i>	New repertoire of actions but not how they relate to values  <i>Limited Effect on Boundary</i>
<i>Building of a Vision</i>	New vision but unfamiliarity remains regarding changes in the surroundings  <i>Limited Effect on Boundary</i>	New vision but confusion in translating vision into actions  <i>Limited Effect on Boundary</i>	Builds vision that allows a new identity and value set to be accepted  <i>Positive Effect on Boundary</i>

6.5 Application of the Framework

The purpose of the study was to suggest a framework of boundary management that is capable of being applied in an action research mode to manage an actual amalgamation. The proposed framework identifies the broad boundary issues that will be faced in an amalgamation and the tensions that each creates. In this respect the managerial capacity to reduce the tensions and smooth boundary transitions can be identified and planned in any given situation. A core proposition within the framework is that different invention types are successful

at resolving different types of boundary problems. Successful integration and resolution of potential boundary problems therefore is a function of tackling each of the three boundary categories with the appropriate intervention type.

## **6.6 Conclusion**

The discussion on the financial study has extended the theoretical understanding of boundary management in M&As in a number of ways. The literature review highlighted that boundary change involved tensions, this chapter has identified the tensions that are created by physical, behavioural and cognitive boundaries.

The tensions arising are as follows:

1. Physical boundaries create unfamiliarity in work surroundings;
2. Behavioural boundaries create confusion with work behaviours;
3. Cognitive boundaries challenge work values or identity.

The case relates these tensions to management interventions suggesting that particular intervention types, contact and awareness building, training and support, and vision building impact on boundaries in different ways. Table 6.5 proposes impacts. In summary:

1. contact and awareness building primarily build familiarity and impact most strongly on physical boundaries;
2. training and behaviour support reduces confusion and impacts most strongly on behavioural boundaries;
3. Vision mediates the challenge to values and identity and impacts most strongly on cognitive boundaries;



4. an integrated approach that adopts all intervention types will be required to change boundaries during an M&A.

Table 5 .8 develops the framework established in table 2.4 and achieves the objective of the second pillar of the research design relating management interventions to boundary categories. This allows the next study adopt these theoretical insights in order to address how boundary change occurs in practice and to explore how boundary salience arises. This will be achieved by applying the framework (table 6.5) within the hospital study in an action research methodology.

## 7 Building Theory from Practice: The Hospital Study

### 7.1 Introduction

It has been argued earlier that the best way to understand boundaries and how they function is to explore changes to boundaries through practice. The third pillar of the research design is an action research study combining the theory developed to date (from the literature understanding and from the financial study) to design and implement a change intervention to successfully merge two organisations. This chapter sets out the story of the amalgamation<sup>33</sup> of the hospital services in South Tipperary. The amalgamation involves two hospitals, Our Lady's Hospital Cashel (Cashel) and St Joseph's Hospital Clonmel (Clonmel), merging to create South Tipperary General Hospital (STGH). The case is complicated by the fact that all three hospitals exist throughout the case. Rather than creating STGH when the amalgamation of services occurred (in 2007), STGH came into being in 1996 with the redesignation of St. Joseph's hospital to STGH. All new contracts of employment post 1996 were with STGH but the pre-1996 Cashel contracts remained with Cashel. By 2007 there were three groupings of people: staff of Cashel origin (and with contracts with Cashel), staff of Clonmel origin (with Clonmel originating contracts) and staff employed with STGH contacts (who could be working in Cashel, Clonmel or both<sup>34</sup>).

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<sup>33</sup> The actual event was the merger of the hospitals but the term amalgamation of services was used in early announcements of the merger and was in common discourse within the hospital. The case narrative will remain true to the actual discourse of the hospital.

<sup>34</sup> Some combined service provision (i.e. dietitians) worked on both campuses.



The purpose of the chapter is to provide an understanding of the context and specific circumstances of the case as a prelude to describing and discussing the boundary issues that emerged. It describes the action research cycles as they moved from planning to implementation and how the theory developed in the financial studies case informed discussions and understandings. The application of the theory in the study allowed the theory to be further developed and its relationship with real practice issues to be understood, particularly the understanding of boundary salience. This is explored in the next chapter.

Consistent with the model of action research as cycles of diagnosing, planning and evaluating action as indicated in figure 3.1 earlier, the study can be divided into four cycles of action. Each cycle commences and ends at natural break points emerging from the conclusion of the actions intended. The complex nature of the operating environment made it impossible to predetermine time limits for each cycle because the timing of actions could not be predicted due to factors outside the control of management. For example industrial relations issues or failure to secure government funding could result in delays or indeed truncate expected cycle times. The case narrates four cycles of action and reflection.

These are summarized in table 7.1. This table serves as a guide to understanding the flow of the narrative. The chapter will explain the context of the merger and the difficulties that the management faced in bring the merger to fruition. The narrative is designed to weave together the various strands of the data, including reflections, interviews and questionnaires, to describe the decisions that were being made and how the pattern of information and opinions was informing the development of understanding. This is important in the context of understanding

boundaries. Earlier in the thesis the concept of boundaries as latent with potential to create conflict was discussed. This social view of boundaries suggests that understanding the social interaction around boundaries will inform understandings of how boundary salience emerges or not as the case may be.



Table 7.1: Cycles of actions and reflections in the hospital study

Cycle 1			Cycle 2		Cycle 3		Cycle 4	
Time line –start	Nov 2003		April 2005		August 2006		13 <sup>th</sup> January 2007	
Time line –finish	March 2005		July 2006		12 <sup>th</sup> January 2007 (merger day)		October 2007	
Cause of cycle end	Combination of industrial relations problem (staff withdrawing from process) and planned cycle of data collection		Re-engagement of staff		Actual merger day and transition to post-merger processes		Final reflections on merger and formal declaration by hospital of its completion	
Issue to be addressed	Lack of belief that merger would occur and lack of contact between hospitals		Maintain momentum of staff working together while industrial action is ongoing and build a common vision for the new hospital		Translate the progress to date into the actual merger.		Mainstream learning and ‘finish’ the merger process	
Objective(s) of the cycle	<div>a. build awareness within each hospital of the activities and culture of the other hospital</div> <div>b. create a sense that the amalgamation would in fact really occur</div> <div>c. establish the process by which the staff of both hospitals could come together in an integrated way at the prescribed amalgamation date</div>	<div>a. Maintain momentum that had been created in cycle 1 for generating common operating and procedural processes and understanding</div> <div>b. redesign the process of communicating to develop greater clarity on the post-merger Cashel position and treat the Cashel cohort with letters of comfort as a distinct group</div> <div>c. fostered actions to engage Cashel and Clonmel staff in common processes</div> <div>d. canvass government for the funding necessary to define and deliver Cashel’s post-merger services in line with the high court agreement</div>	<div>a. the Hospital Manager engaging all groups and addressing all issues as promptly and effectively as possible</div> <div>b. Increasing the range and number of actions that serve to integrate and homogenize processes</div> <div>c. Involving the Cashel post-merger community, at the earliest stages, in the development of services in Cashel</div>	<div>a. Ensure emerging issues have a conduit through which they can be resolved</div> <div>b. Continue to build identification with STGH and common values among staff</div> <div>c. Evaluate the level of integration achieved</div> <div>d. Slowly migrate outstanding issues to the normal operating and responsibility structures of the hospital</div>				

Cycle 1					Cycle 2					Cycle 3					Cycle 4					
Actions	Enhanced communication focused on the resolution of task problems and the building of common processes and understanding by implementing the boundary reducing actions					Focus on establishing a common mission statement with agreed hospital-wide values and on adopting a unified quality framework for both hospitals					Strengthen structures to resolve issues and increase the amount and frequency of meetings, engaging as widely as possible. Establish externally driven target date					Homogenised activities and resolved problems as they emerged. Formal launch of mission statement and celebrations of success				
Outcome(s)	<ul style="list-style-type: none"><li>a. divergent perceptions on quality of communication</li><li>b. greater belief that merger would occur and strong processes established</li><li>c. industrial action resulting in withdrawal of nursing staff from merger process</li></ul>					<ul style="list-style-type: none"><li>a. Acquisition of funding to complete the Cashel services post-merger</li><li>b. substantial consistency in operating processes and procedures</li><li>c. creation of agreed mission statement</li><li>d. substantial pay compensation claim initiated by unions</li></ul>					The merger of services at South Tipperary General Hospital					High levels of satisfaction with merger achieved and common process and levels of integration delivered				
Organisation Learning that informs next cycle	<ul style="list-style-type: none"><li>a. Two groups exist in Cashel hospital and they must be engaged differently</li><li>b. Working groups can bring staff together and build commonality</li></ul>					<ul style="list-style-type: none"><li>a. Need to broaden participation to include, particularly, the Clinical leaders.</li><li>b. Multiple visions were needed (i.e. hospital, external community etc)</li><li>c. Need to focus on a target date</li><li>d. Leadership role of GM must be seen to be strong</li></ul>					<ul style="list-style-type: none"><li>a. Cycle of change was substantial and difficult for all</li><li>b. Need to mainstream issues as soon as possible</li><li>c. Team structures work well and should be used as a means of future development</li><li>d. Need to continue to build and support hospital vision</li></ul>					<ul style="list-style-type: none"><li>a. continue with team structures</li><li>b. boundary theory did help inform processes</li><li>c. some staff still left behind and found (finding) transition difficult</li><li>d. Accreditation of hospital continued with existing group structure</li><li>e. Hospital strategy to be developed adopting from same participative structures as amalgamation process</li></ul>				



## 7.2 The Context

Every major town wants a hospital to provide for the health of its population. Ordinarily, it is easy to decide where hospitals should be located as areas usually have dominant population zones that justify the centralization of hospital services in that zone. Occasionally, the decision is more complex as two towns of relatively equal size are located in one region and both compete for the location of services. South Tipperary was one such region with two large towns, Cashel and Clonmel, vying for the location of the county hospital. Political decisions as far back as the 1920s created two distinct hospitals, a surgical hospital in Cashel and a medical hospital in Clonmel (Lonergan, 2000). Hospital services developed around these two hospitals to include psychiatric, community care and care of the elderly facilities.

Developments in healthcare, including multidiscipline team methods, meant that by the 1990s the separation of surgical and medical facilities created high levels of clinical risk. When a patient required both medical and surgical procedures they would have to be transferred, twenty-five miles, between the two hospitals. The separation of services was untenable and could not be sustained. The surgical and medical units had to be brought together in one facility. In 1995, the Minister for Health announced the amalgamation of the two hospitals and the creation of a new hospital, South Tipperary General Hospital (STGH), to incorporate the two previous hospitals into the existing hospital site in Clonmel. The decision to close the Cashel hospital was met with resistance in Cashel. There was a strong perception of loss and that the facilities were being taken away from the town of Cashel. A hospital action group was formed to fight the

perceived loss and a campaign of protest began. In the end a legal agreement between the Department of Health<sup>35</sup> and the action group was reached, and lodged in the Irish High Court (this became known as the high court agreement). The high court agreement facilitated the redevelopment of services in such a way as to allow primary and community care facilities to remain in Cashel and for the surgical operations to be moved to Clonmel. As part of this agreement, staff in the Cashel hospital received 'letters of comfort' guaranteeing that they would not have to move to the Clonmel hospital unless they so wished. Positions for all existing staff would be made available in the new services developed in Cashel<sup>36</sup>. All new appointees would, however, have contracts with the new hospital, STGH, and would be obliged to move to Clonmel when the transfer occurred. The high court agreement was hugely important in the study and it shaped significantly the choices that were available to planners and managers. The agreement had to be followed.

The operation to transfer the services was planned to occur in a number of phases, commencing with the redevelopment of the existing hospital building in Clonmel, including the building of a new surgical and emergency wing to the existing hospital. The second building phase involved the refurbishing and rebuilding of new facilities in Cashel to provide for the new services that would be developed there. Government funding was released on a phased basis and came in a stop-start manner with small parts of the project funded at a time. This did not allow for the development to take place in a seamless manner. Clonmel

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<sup>35</sup> The Government ministry responsible for hospitals and health provision

<sup>36</sup> This letter of comfort guaranteed that they would maintain their grade, rank and salary but did not guarantee that they would maintain the same tasks (e.g. a surgical nurse could be assigned to geriatric care).



completed the capital programme in 2003 but Cashel's funding was much slower to progress and building completion was still ongoing post amalgamation of services.

The focus of management turned to ensuring effective staff integration post-merger in early 2003 as the building programme in Clonmel came to completion and the first real opportunity to bring the two hospitals together was emerging. It was hoped that the funding to complete the staffing and equipping of the new hospital would be available in mid- to late-2004 and the two hospitals could be brought together before the end of 2004. A major stumbling block however was that the Cashel development phase had not commenced: the government had not released the money for the development and it was not certain what services would be funded. This created major disquiet among staff in Cashel, particularly those that had the right to stay under the high court agreement.

## 7.3 Cycle 1

### 7.3.1 *Diagnosing the Problem*

The common perception within the hospitals in 2003 was that the amalgamation of services might never happen. The logic of amalgamating was well understood and generally accepted, although the amalgamation had made little progress since it was announced in 1995. The hospital management team (which was common to both hospitals<sup>37</sup>) was working to deliver the amalgamation and the

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<sup>37</sup> All of the administrative management team was employed by STGH, this included the Hospital Manager, deputy manager, the Integration Manager and the business development manager. They accordingly worked across both hospitals. Separate clinical and line managers existed within each hospital.

building of the physical infrastructure had progressed substantially. However, the business of the hospitals in both Cashel and Clonmel continued as usual and the daily pressures of managing and operating the hospitals was the primary concern of staff and clinicians. This reinforced, particularly in Cashel, a view that the amalgamation would either not take place or would occur only in the very distant future. The hospital management identified a number of specific problems in moving the amalgamation forward:

1. A general belief existed among staff that the amalgamation would never occur and this was evidenced from the long delays that had already taken place.
2. There was a perceived lack of information and awareness about the amalgamation and the operations of each hospital.
3. Staff members were not properly prepared for the amalgamation and did not really know what to expect in the build-up to amalgamation or the circumstances of the hospital(s) post amalgamation.

In an attempt to address these issues, an integration management structure was developed which included, an executive group responsible for the overall management of the process, an operational group to identify and manage tasks that needed to be addressed and a partnership structure to engage staff in the operations detail and to work across Cashel and Clonmel on areas of mutual concern. I became involved with the management team through links between my employing institution, Waterford Institute of Technology and the Hospital's Governing Health Authority. After initial meetings with the Hospital Manager and an exchange of views on change I was asked to become an external



facilitator and change agent. I worked with the executive group to provide an external perspective and to assist the group in identifying and reflecting on appropriate actions. The Hospital Manager, the Integration Manager and I established an insider/outsider group<sup>38</sup> and commenced a dialogue on the issues around the amalgamation process and how the problems might be addressed and framed. At this early stage we discussed the structural issues and potential problems that might arise with a particular focus on the 'merger day' and working out what had to happen for that day to run smoothly. I suggested that I should spend some time getting to know the context of the hospital and the people involved and this was facilitated by the Hospital Manager. I subsequently held discussions with a number of key participants including the Assistant General Manager and the Directors of Nursing (in Cashel and Clonmel).

These initial discussions highlighted the multiple dimensions to the difficulty in getting the groups in Cashel to transfer. We had started discussing the perception of the merger among staff and particularly that the discussion on the transfer of services had gone on for so long that it failed to make any real impact on their lives or 'reality,' particularly in Cashel where it was very easy for staff to discount or deny that it would ever be realised. The Cashel, staff was physically removed from the major building works that had occurred in Clonmel, they continued with their daily tasks without any changes, and some of the Cashel formal and informal leadership, (nursing and surgeon groups) supported the continuance of the status quo. In our discussions we set about defining why this

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<sup>38</sup> This will be referred to as the research group and co-researchers

might be the case and uncovered multiple reasons why in the minds of Cashel staff the transfer could not occur:

1. The letters of comfort held by staff could not be renegotiated and accordingly staff had the power to reject any offers. They could not be forced to go to Clonmel.
2. Surgeon support was not readily evident and that their support was essential to the move.
3. There was no money available from the HSE to pay for the transfer.
4. The people of Cashel would never let the hospital move occur as it was an unacceptable loss to the community.
5. The Cashel Hospital Action Group would never let it happen.
6. Decisions had been made before about the location of hospitals and never followed through, why would this be any different?
7. Cashel was an effective well run hospital, why would they move or change it.
8. Too many clinical and staff issues would arise and these could never be resolved.
9. The terms and conditions enjoyed in Cashel could not be changed.

The transfer of services would have substantial impact on the lives of staff in Cashel and many industrial relations issues existed as a result. While staff would transfer to the same jobs by and large, the extra distance<sup>39</sup> to travel to work had impact on their personal lives with extra time required for commuting. This would be more significant for staff that had personal commitments with either

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<sup>39</sup> Clonmel was approximately 40 kilometers (25 miles) from Cashel which constitutes up to an extra 30-40 minutes driving time each way.



elderly relatives or young children. Additionally, the transfer to a full service hospital required new working structures. The most difficult issue was on-call duties. The new STGH required certain on-call commitments from staff and this represented a major problem for some staff members who could not be away from home or could not travel the distance from home if called into the hospital. Cashel staff, traditionally, was not forced to do on-call and this would therefore represent a major change to their terms of employment<sup>40</sup>. From the research of the Integration Manager many other problems also existed and these related to service issues. In a briefing document prepared for the hospital management, the Integration Manager interviewed the staff in Cashel and collated a full list of items that were of issue to staff. She classified them under four headings, working conditions, work practices, issues relating to the HSE and finally facilities for staff.

The action research dialogue at this point focused on what the hospital wanted to achieve in the merger process and what constituted success. The overriding theme was the need to '*avoid a hospital within a hospital.*'<sup>41</sup> The Hospital Manager defined this as avoiding two distinctive groups of staff, one from Cashel and one from Clonmel, who may share the same hospital space but do not share common operating procedures, protocols or cultures. This had occurred in previous hospital mergers in Ireland and presented a real risk to the STGH management. The risks were operational inefficiencies and poor clinical management structures. The Hospital Manager was also acutely aware that changes in health provision and particularly the need to create economies of

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<sup>40</sup> Their job contracts require them to do on-call duties but the custom and practice within Cashel never enforced the requirement.

<sup>41</sup> Phrase used by the Hospital Manager.

scale and specialisms made smaller county hospitals vulnerable. An ineffective merged hospital could lose services to larger regional hospitals. It was therefore quite important that the hospitals not only merged but that they also integrated effectively once they did merge.

The action research discussion led to a number of key short-term and long-term goals. To achieve high levels of integration post-merger the hospitals would have to create a common frame of reference for each hospital to work together.

Management was also keen to create processes of organisational learning that would develop a sustainable and progressive culture within the new hospital and lead to ongoing quality improvement. The boundary framework (table 5.8) presented a potential framework to direct action toward these goals and its applicability to the merger problem seemed appropriate. It also served a more immediate purpose. Getting people working together and reducing perceived differences between groups would assist in challenging the prevailing perception that the merger would not happen. This was seen as a first primary step.

Agreeing this boundary model is an example of how the working relationship with my co-researchers would develop. We had had a number of discussions, particularly through the executive team meetings on issues of communication needs and on specific integration issues such as building staff contact and common operating procedures. In preparation for the meeting with the Hospital Manager I presented a paper on the boundary model to her (and also to the Integration Manager). At the meeting we discussed the outcomes of the financial study based on this paper and whether this could be used in the hospital more directly. We explored the perceived boundaries in the hospital and the discussion



uncovered a number of boundaries that fitted within the framework. This led us to sketch out a number of actions that supported the framework (see table 7.2) and which we later discussed with the integration manager. However my co-researchers were concerned that the environment of the hospital might be different and that the role of the consultants and surgeons might need to be incorporated in some way. It was suggested that the model should be presented to the consultant and surgeon groups for them to explore how they see boundaries within the hospitals. I agreed to undertake this task and the co-researchers agreed to consult with the consultant/surgeon group. In the end that group would not agree to discuss the framework with me. This example shows how reflections and ideas can lead both to action and resistance.

As the first cycle of planning and diagnosing concluded, the action research team set about defining an action cycle. We agreed that the main purposes of this cycle were threefold:

1. Firstly, it was designed to build awareness within each hospital of the activities and culture of the other hospital (as a means of identifying and reducing boundary conflicts post-merger);
2. Secondly, it sought to create a sense that the amalgamation would in fact really occur and
3. Finally it sought to establish the process by which the staff of both hospitals could come together in an integrated way at the prescribed amalgamation date. In this way the process was targeted at avoiding the problem of 'a hospital within a hospital'.

7.3.2 The Action Phase: Building Belief

In discussing the boundary framework the research team identified a number of activities under each intervention type and the hospital management commenced a focused programme aimed at both communicating the changes and creating appropriate actions that reinforced the communication. A summary of the actions is presented in table 7.2. This table reproduces the framework created in the financial study and identifies the exact actions the hospital would take to reduce physical, behavioural and cognitive boundaries within an integrated approach.

Table 7.2: Actions taken to create integration

Planned Actions	Physical Boundaries	Behavioral Boundaries	Cognitive Boundaries
Contact and Awareness Building	Staff exchanges Staff open days Integration Newsletter Partnership groups Staff briefing Hospital Manager led Information booth Integration Manager appointed		
Training and Behavior Support		Staff swap days Integration training days Task groups to determine work practices (partnership) On-going training	
Building of a Vision			Leader involved at all levels Clear vision ‘ a better service for Sth Tipperary’ Partnership Groups working on values (e.g. Nursing philosophy) Feedback mechanisms Statements of comfort Redraft Mission Statement Open communication channels and dialogue



#### 7.3.2.1 Contact and Awareness Building

The Integration Manager implemented a number of initiatives to increase the general level of awareness about the amalgamation process. A central plank was a monthly amalgamation newsletter that included progress reports from each of the three task groups (executive, operational and partnership) as well as general information such as reports on major events, or the profiling of individuals or departments. The information dissemination was supported by physical actions aimed at achieving two primary goals, reinforcing the communication message that this amalgamation was going to occur and secondly, creating opportunities for interaction between staff. Through the executive group, senior managers were encouraged to initiate staff exchanges; individuals from one hospital would spend a day or more in the other hospital. Initially the staff exchanges worked well with participants reporting positively about their experiences. However, as time progressed the pressures of work reduced the physical numbers wanting to or being able to participate in the staff exchanges.

The Hospital Manager also led by example, trying to enhance communication and awareness. She presented staff briefings on a regular basis, personally feeding back information to the staff. She also met with the unions and staff groups on a regular basis and adopted an open door policy providing access for any staff member to meet with her. She also organized 'information booths' where the Hospital Manager and the Integration Manager were available to meet with staff to discuss any amalgamation issue at prescribed times and places.

Similarly, a strong effort was made to increase contact between the two hospital groups through a staff-exchange programme and the partnership groups. This achieved a great deal of contact as the people and groups came together to deal with task-related issues and resolve real problems in both formal and informal settings. The partnership groups were slow to start but did achieve a great deal in terms of homogenizing operating and procedural issues. The Integration Manager also organized a sequence of 'integration days' where groups of staff from both hospitals came together for a day to discuss the amalgamation and what needed to happen as the amalgamation occurred. The integration days were designed to tackle not only the physical issues concerning the amalgamation but also the psychological and emotional issues.

#### 7.3.2.2 Training and Behavioural Supports

As well as building awareness many of the activities also provided additional training to staff. For instance the partnership groups provided new operating protocols that were translated into new actions on the ground through ongoing training and development. The staff-exchange programme exposed staff to alternative ways and acted as a process to homogenize practice as each group reflected on their systems in the light of what they saw in the other hospital. In addition the hospital's ongoing processes of staff training and procedure development were harnessed to implement the outputs of the partnership groups.

#### 7.3.2.3 Building of a Vision

The need to build a vision of the future for South Tipperary General Hospital was well recognized and the executive group identified and implemented a



number of initiatives in this respect. A primary factor was the involvement of the Hospital Manager as a key figure in sponsoring the change. From early in the process she recognized the need to build trust as a bridge toward working with the staff, unions and other parties involved in the amalgamation. Participation, openness and honest dialogue were the cornerstones of the philosophy that she espoused. She led by example adopting this philosophy from interactions at the most senior board levels to making herself available to meet with individual staff at any time. Her vision was clear that working together to create the amalgamation was needed to ensure '*a better service for South Tipperary*'.

The vision was underpinned by a number of initiatives that emphasized an open and participative approach to create the new South Tipperary General Hospital. This included the creation of a '*Philosophy of Nursing in South General Acute Hospitals*' drafted by the nursing staff in the two hospitals. The action cycles also collected data on the perceived progress of the amalgamation and presented the findings to staff. This provided processes for wider input and dialogue on the amalgamation and created more open and transparent feedback mechanisms. The hospital management also continually reaffirmed the commitment to staff arising from the letters of comfort staff received in 1995.

The hospital also affirmed culture and values by commencing a hospital-wide dialogue on a new mission statement. This was designed to get staff to think about the type of hospital they wanted post amalgamation and to create ownership of that culture. The first staff questionnaire (described later) devoted a number of questions to the mission statement and its underlying values. In

addition focus groups were established within both Cashel and Clonmel to discuss the findings of the questionnaires to provide greater staff inputs and deeper management understanding of staff views. This entire process was facilitated by external people (part of a research team at Waterford Institute of Technology but under my direction and quality control) to distance the process from perceived management interference.

#### 7.3.2.4 Concluding the Cycle

The 2004-5 period was characterized by significant progress toward a unified hospital. The Cashel and Clonmel groups had engaged each other and substantial interaction and understanding between the two groups had materialized. In addition, significant work on integrating operating procedures had occurred with many common work practices and pathways developed. By early 2005, patient pathways had been developed and applied consistently in each hospital. Other common procedures were also developed such as drug application charts and administrative procedures. The dialogue emerging from the partnership and training forums and the close working together of groups in teams further enhanced connectivity and commonality between the two hospitals. Specific groups had been tasked with resolving the hitherto 'irresolvable' problems around the merger and many of these issues were now being resolved. Some issues, particularly those around the services remaining in Cashel under the High Court Agreement and the compensation to staff (with letters) for transferring, could not be addressed by any internal forum as their implications required the agreement and action of the wider HSE. Nonetheless, the physical and staff changes required to bring the hospitals together were now falling into place.



There was a strong feeling in management that staff perception had shifted to a realisation that the merger was going to be delivered and that the interventions were producing dividends.

By late 2004, a further change impacted on STGH. As a means of developing a more consistent and coherent quality culture across the health sector, the Health Service Executive (the governing central agency for health care in Ireland) commenced an accreditation process to certify quality in every hospital. All hospitals, nationally, had to undergo a self-evaluation and an external assessment to benchmark itself against pre-determined criteria and develop appropriate developmental plans. The process involved a fundamental review of all activities and required each hospital to establish a number of working groups. While hospitals could choose their own timeline to accreditation, STGH decided to work toward accreditation as soon as possible and they subsequently commenced the process in November 2004. Initially this work was undertaken as two separate hospitals, Cashel and Clonmel, (which reflected the reality on the ground) but brought together by a common facilitator.<sup>42</sup> This decision created a body of work which was driving toward best practice and which could unify both hospitals. To be accredited both hospitals would be forced to review and update their operating processes and create common patient pathways.

By early 2005 progress was apparent and there was a sense among management that the first major cycle of action had delivered results. We therefore decided that it was time to gather more formal feedback from staff on their perceptions of

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<sup>42</sup> The accreditation manager was also the Integration Manager.

the progress through the application of a hospital-wide questionnaire. As this was happening the progress took a sharp change of direction. In April 2005, the nursing union (INO) branch in Cashel decided that it was unacceptable that the staff in Cashel did not know what services were to be funded by the government in Cashel post-merger. They argued that this issue made it impossible for the staff to decide whether or not they wanted to invoke their letter of comfort and stay in Cashel or transfer to Clonmel. Tired of not getting a commitment from the HSE for the funding to develop services in Cashel, the INO served notice on the STGH management that they would no longer participate in any activities concerned with the amalgamation of services, effectively withdrawing all Cashel nursing staff from the partnership and team structures that were driving the integration of the two hospitals. The accreditation process, however, remained outside the scope of the industrial action.

#### 7.3.2.5 Gathering Feedback

In early 2005 a review of the progress made to date commenced with the application of a hospital-wide questionnaire to all staff (see section 4.3.4.2) and appendix 9). A total of 403 questionnaires were sent out to a staff through the payroll system. The response rates from the two hospitals differed but in both cases it was well below expectations. The final response rate for Clonmel was 27.4% (61 responses) and just 10% (18 responses) for Cashel. Follow-on discussions between the Integration Manager and staff who did not fill out the questionnaire suggested that the position of the union opposed to further participation in integration activities had a large impact on the Cashel response rate. The overall response rates were disappointing and the extent to which the



data is representative of the hospitals is as a result questionable<sup>43</sup>. However the purpose of the data collection was not to create a generalisable picture of the hospitals but to establish the perceptions of staff. In this respect the data does provide a useful picture. Indeed possibly the most significant outcome of the data collection is the low level of response. The issues were clearly not that important to many of the staff in both hospitals and/or they did not want to engage the issue of the amalgamation. A series of feedback sessions were held to explore the results with the various communities, including a feedback session to the executive management of the hospital, a plenary session on the Clonmel campus and a plenary session at the Cashel campus. Consistent with the questionnaire response rates, the attendance at the Cashel site was relatively poor with less than 10% of the hospital staff in attendance.

### *7.3.3 Outcome and Reflections*

The analysis of the data and the discussions with staff provided some interesting and unexpected results for the management. Despite a uniform and consistent process of communication and contact building there appeared to be a divergence between the two sites in terms of their perceptions about the amalgamation. In general the Clonmel site reported positive experiences about the amalgamation and felt that they had participated in the process and received relevant data about the transfer. All in all they were positive and in favour of the transfer. In contrast the Cashel site felt uninformed, lacking in relevant information about what was happening and in general felt more neutral toward the amalgamation. Table 7.3

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<sup>43</sup> The importance of this became more significant later when it was realized that the dominant groups in the hospital may have been influencing the opinion of others.

presents the mean scores for the perceptions about the awareness and progress of the amalgamation.

Table 7.3: Mean and standard deviation scores for perceptions of awareness

Statement	Clonmel		Cashel	
	Mean	Std Dev	Mean	Std Dev
I am up to date on how the transfer of services is progressing	5.02	1.698	2.76	1.855
There is a general information overload with either too much information available or not enough time to understand it	3.00	1.673	2.59	1.938
The information I have received about the transfer of services is relevant to me	5.11	1.845	1.59	1.121
I would like to receive more information on the transfer of services	4.97	2.168	6.53	1.179
I am happy with the progress being made to date on the transfer of services	3.80	1.720	2.24	1.855
I have contributed to the groups or partnership committees working on the transfer of services	3.40	2.264	4.29	2.592
I would like to contribute to the groups or partnership committees working on the transfer of services	4.89	1.979	4.41	2.451
I believe the partnership process is working well	4.20	1.641	2.18	1.510
I understand the logic behind the transfer of services	6.58	0.850	4.47	2.211
I think progress on the transfer of services is too slow	5.28	1.863	5.59	1.839
I think the transfer of services will improve the services to patients	6.66	1.047	4.41	1.970
Yes, I am in favour of the transfer of services	6.72	0.915	4.00	2.449

*Statements were ranked on a scale of 1-7 where 1 represented complete disagreement and 7 represented complete agreement.*

A similar pattern emerged for the extent to which the hospital staff identified with their hospital of heritage or the new South Tipperary General (see table 7.4). It might be expected that the Clonmel cohort would have some difficulty in distinguishing STGH from Clonmel as the former was in many ways the new name for the old Clonmel campus. Clonmel was therefore expected to identify strongly with STGH. Indeed some comments received questioned the validity of using STGH and Clonmel as they were the same. In contrast Cashel was located away from the STGH campus and might be expected to associate less with it as a result.



The data (albeit limited by the number of respondents) showed a strong Cashel bias toward the membership of the Cashel hospital (6.59) and less desire to be part of South Tipperary General (3.61). In contrast the Clonmel staff felt a marginally greater identity with South Tipperary General (5.98) than with the hospital of heritage (5.53). The scores for the Clonmel/South Tipperary General identity are very similar and this may indicate that there was a difficulty in the Clonmel site that conflated the two identities.

Table 7.4: Mean and standard deviation scores for identification scales

Statement	Clonmel		Cashel	
	Mean	Std Dev	Mean	Std Dev
I see myself as being from (named hospital of heritage)	5.18	2.205	6.35	1.618
I am pleased to be a member of (named hospital of heritage)	5.83	1.749	6.82	0.728
I feel strong ties with (named hospital of heritage)	5.19	2.004	6.47	1.281
I identify with other members of (named hospital of heritage)	5.53	1.837	6.59	0.870
Being a member of (named hospital of heritage)is important to me	5.42	1.792	6.11	1.641
I see myself as being from South Tipperary General Hospital	5.74	1.763	2.76	2.463
I am pleased to be a member of South Tipperary General Hospital	6.10	1.630	3.00	2.574
I feel strong ties with South Tipperary General Hospital	5.40	1.991	2.82	2.351
I identify with other members of South Tipperary General Hospital	5.98	1.456	3.61	2.279
Being a member of South Tipperary General Hospital is important to me	5.98	1.642	3.11	2.272

*Statements were ranked on a scale of 1-7 where 1 represented complete disagreement and 7 represented complete agreement.*

Further data were collected on the understanding by each hospital of the merger partner (Table 7.5) and the analysis suggests that the each group felt well informed about the other. Given the amalgamation days, the staff transfers and the partnership and accreditation groups, this result was expected. There was a consistent feeling that the work context of each hospital was different (probably based on the surgical and medical divide) yet the two groups’ attitude toward the level of cultural convergence showed alternate views. The Clonmel group felt

that the hospitals were culturally similar (4.57) while the Cashel group felt less confident of their similarity (2.72). The Cashel mean score however needs to be considered in terms of a high standard deviation of 2.137. The responses incurred a large number (45%) of very negative responses, which influences the mean disproportionately. This data conflicted strongly with the data on values and on preferred mission statements which demonstrated a strong common bond in terms of the value sets. The groups demonstrated a high degree of similarity in their ranking of important cultural dimensions. Both sites preferred the same mission statements and expressed a similar set of cultural values.

Table 7.5: Mean and standard deviation scores for culture

Statement	Clonmel		Cashel	
	Mean	Std Dev	Mean	Std Dev
There is little difference between the work done in Cashel and Clonmel	2.55	1.692	1.83	1.543
I don't know what they do in the (other) hospital	2.16	1.881	3.06	2.155
The culture in Our Lady's Hospital, Cashel and St Joseph's Hospital, Clonmel is similar	4.57	1.830	2.72	2.137

*Statements were ranked on a scale of 1-7 where 1 represented complete disagreement and 7 represented complete agreement.*

### 7.3.4 Working with Co-researchers in Cycle 1

This section sets out how the collaborative relationships operated and developed throughout the first cycle of action and reflection. The focus of the executive transfer group during this period was on the physical aspects of change rather than the people aspects. Meetings followed a set agenda that consisted of 6 items, notably, minutes of previous meetings, funding, industrial relations, change management, minor capital works and equipping. It is therefore not surprising that the meetings tended to focus on the nuts and bolts of change. An example,



of an issue was the desired ownership of beds by the surgical staff. They want to maintain the bed numbers they enjoyed in Cashel and ring fence them in Clonmel so that medical or A&E could not use them. This was unacceptable from the point of view of those who are responsible for admissions and for allocating beds to patients. Issues such as these were somewhat intractable but we hoped that they would be resolved through dialogue among staff and this method of resolution was strongly fostered by the Hospital Manager. Ultimately, many of these issues only got resolved in the final preparation for the merger. Similarly, significant discussions took place around capital development and minor capital work with a large part of each meeting being allocated to reports on these issues. Industrial relation issues also received significant attention. However, it was acknowledged within the executive transfer team that resolving these issues was only possible through the working group structure so the role of the executive group during this stage was supporting the operational and partnership groups.

The change item at these team meetings concerned the people issues of the merger and how people were engaged (and engaging) the merger. I was identified within the group as the facilitator of discussions on this agenda item. These were discussed at each meeting and I led the issue in terms of inquiring about the level of inter-group activity and communication that was occurring based on the agreed interventions (see table 7.2). My assumption was that by discussing problem areas hospital staff would identify problems and design solutions independently. A general awareness of potential inter-group problems was present but this did not always translate into a solution-orientated action. I was prompted to challenge assumptions about this on several occasions. One

example of this occurred in November 2004, when I encouraged the group to develop more detailed project plans beyond the nuts of bolts of the normal discussions. I decided that I would use stories as examples so that issues could be addressed in a more tangible way. I placed the discussion in the context of thinking about day one – the actual amalgamation day when the two sets of staff combine. I recounted a story of a young person who, on moving to the newly merged office, was embarrassed to ask where the toilet was located and that this served as his abiding memory of the merger day, searching for the toilet. This stimulated a discussion on the minute but important issues that would need to be done, for instance phone lists, maps of facilities and ways of identifying who to contact etc. This was considered a worthy discussion and it resulted in a group being proposed to progress this strand of work (the group subsequently produced a very good directory for the merger day). It became clear however as the discussion unfolded that there was an assumption among the group that it was only Cashel staff that would need support adjusting to their new environment. Indeed, Clonmel staff was almost seen as being the ‘host’ of the Cashel staff with references to their role in welcoming the Cashel staff or facilitating them. This prompted me to intervene with general comments such as ‘don’t forget that the Clonmel staff will be experiencing substantial change as many new people arrive into the hospital.’ While the group acknowledged that change would occur in Clonmel they continued to conceive Clonmel as the leader of the change effort rather than being impacted by it. For instance they continued to plan that the Clonmel staff would welcome Cashel staff to the hospital. To continue to challenge their assumptions I recounted the story (based on the financial study) of the person who was welcomed to a new branch and responded with the



statement ‘why are you welcoming me to my office?’ This was a more direct inquiry about seeing the relationship from the Cashel perspective. This successfully opened the discussion to the difficulties that Clonmel staff had endured as a result of the amalgamation, such as building works and the perceived focus of the merger on Cashel issues at the expense of Clonmel.

Meetings with the co-researchers (the Integration Manager and Hospital Manager) during this period were mostly concerned with scoping out the range of activities that would be needed for the merger. Many of our discussions concerned communication, particularly in so far as it concerned staff in Cashel, for instance by December 2004 information coming from the partnership process highlighted greater levels of participation within Cashel and an increasing shift in perception generally from this amalgamation ‘won’t happen’ to ‘it will happen’. However, the same reports also highlighted that staff were concerned about a number of Cashel specific issues and we discovered through the questionnaire data that the Cashel staff felt uninformed. Our reflections on this issue puzzled us for some time as we tried to work out how the cycle of change simultaneously succeeded (staff had realised the merger would happen) and failed (resulted in industrial action). In our discussions we surfaced two relevant assumptions that we had made. Firstly, that the more the hospital communicated the better the awareness of the merger would be and the greater the support that would be received for it. This needed to be re-thought because the communication did not adequately penetrate the Cashel consciousness – we discussed the reason for this as possibly an information referent effect (Haslem 2001). It was concluded that we needed to be more targeted in this endeavour in the future. Secondly, we had

assumed that the Cashel group was actually one consistent group, while this assumption was being questioned before the end of the cycle, the events and reflections clearly led us to conclude that there were in fact separate groups existing in Cashel.

## 7.4 Cycle 2

### 7.4.1 *Diagnosing the Problem: Rethinking and Consolidating*

The data collected at the end of cycle 1, the meetings and feedback sessions with the executive board and with staff that and the actions of the hospital communities (i.e. the union withdrawal) provided the basis for reflecting on cycle 1 and the setting of objectives for the next cycle of interventions.

Ironically, it was clear that the first cycle of action had been successful, but it had resulted in the nursing union withdrawing from further participation until their outstanding issues were resolved. Their withdrawal effectively brought the partnership approach to a standstill. The campaign to build belief that the merger would happen had worked. The union could not have withdrawn from the process otherwise (they would have had nothing to withdraw from and no reason to withdraw). But an important lesson was also learned. The design of the action cycle had assumed two separate and distinct groups, Clonmel and Cashel. In fact there were three groups, with the Cashel group comprising two groups, one that was planning to stay and one that was going to transfer over to Clonmel on the amalgamation date. The group that would remain represented the longer-serving members of staff and they generally had greater formal and informal authority and position. The impact of communicating with the Cashel cohort as a unified



whole was that the communication was often focused on aspects of concern to one section of the community only (i.e. on STGH post-merger) rather than on what the dominant discourse within the hospital portrayed as the key purpose of communication (i.e. what was happening to the remaining services in Cashel). The strength of the dominant discourse was maintained by the stronger and more influential senior staff; those with the letters of support. Communications to Cashel were therefore less relevant or effective than anticipated. Furthermore it allowed the more dominant group to highlight the lack of communication concerning their issues and intensify the perception of the community as a whole that the merger was not ready to happen.

Based on the reflections on cycle 1 it was clear that the second cycle could not drive the amalgamation forward until the nursing union re-entered discussions with management. But it was also clear that based on the momentum that had been built up over the past year that a number of other activities could continue to build on that momentum and facilitate the amalgamation once the unions returned to the negotiation table. Building from these achievements and realizing that the direct continuance of the amalgamation process was impossible without the direct involvement of the unions and staff, the second cycle of actions was designed to continue bringing staff together to work on hospital improvements with the long-term aim of facilitating the merger once the union issues were resolved. This strategy worked to create new boundaries by homogenizing task and operating activities through creating and sharing best practice. The actions identified in table 7.2 were reinforced by these activities. The research team therefore agreed that cycle 2 would have the following objectives:

1. The momentum that had developed in creating a common operating and procedural understanding would be developed. The main mechanism for achieving this would be the accreditation process.
2. The needs of the Cashel cohort, as two separate groups would be met and a process of communicating and developing greater clarity on the post-merger Cashel position would be instigated.
3. Where possible actions to engage Cashel and Clonmel staff in common processes would be fostered.
4. Continue to canvass government for the funding necessary to define and deliver Cashel's post-merger services in line with the high court agreement.

Actions therefore concentrated on building capacity for integration through fostering common activities while canvassing government for the funding to address the unresolved Cashel issues.

#### *7.4.2 The Action Phase: Building Capacity*

The period April 2005-July 2006 was characterized by less direct attention to the amalgamation and more to the instruments of integration that would result in the two hospitals working together more effectively post-merger. Only four executive transfer team meetings were held between April 2005 and July 2006. The industrial relations position obviously reduced any capacity for the management of the hospital to directly or visibly move the amalgamation forward. The huge momentum that had been developed in the previous action



cycle however had created a great deal of commonality between the two hospitals homogenizing many operating and administrative systems.

One strong instrument of integration was the accreditation process, which offered an opportunity to build on existing achievements and maintain many of the interactive process that had been initiated in cycle 1. A number of accreditation groups had been formed around specific issues, for example surgical or medical care, which followed naturally the divide in the two hospitals but also forced groups to integrate with the other hospital. From April 2005 onward these accreditation groups worked on building a new quality environment at the hospital, in line with national practice. This process reinforced the need to bring the two hospitals together as it was evident to most that individually the hospitals could not pass the accreditation process. The implications of failing to achieving accreditation might include a reduction (or elimination) of services and the potential loss of these to more 'effective' hospitals. Staff was therefore motivated to participate and deliver on the accreditation agenda.

A second instrument to create cohesiveness across the hospitals was the development of the STGH mission statement. The questionnaire applied in April 2005, had asked specific questions on the preferred mission and on the values and cultures the staff felt should be the foundation of the new combined hospital. A strong sense of consistency existed between respondents, emphasizing patient care and a safe environment for patients and staff. Given the small number of respondents to the questionnaire the mission debate was extended. Plenary sessions on the questionnaire results (and their weaknesses) were presented at

two separate presentations to each hospital group. Two additional focus groups, one in each hospital, were held to discuss the mission statement more fully. The outputs of these discussions were subsequently used to present a number of options to the Hospital executive. In June 2006 the Hospital executive approved its new mission statement subject to staff and community comment. The June issue of the staff newsletter carried the new statement and asked for feedback.

The agreed statement read:

*At South Tipperary General Hospital we will strive to enhance the health and well-being of the people we serve.*

*To achieve this we will*

*Place the patient at the centre of our activities*

*Maintain the dignity and respect of our patients and staff at all times*

*Develop the highest professional level of service consistent with national and international best practice*

*Provide an environment that is safe and welcoming*

The tone of the mission statement and its simplicity was specifically designed to be personal through the references to 'we' and 'our' and to act as a clear statement of unity and consistency across both hospitals by providing higher order objectives, for example 'wellbeing,' 'health' and 'professional'.

Throughout this period the unresolved amalgamation issues were still centre stage, particularly in the mind of the Hospital Manager, and a strong business case had been put to the HSE to develop the Cashel site and provide the necessary funding for completion of the amalgamation. Ongoing and strong



representation from the hospital management resulted in a favourable decision in early summer 2006 and the Department of Health and Children through the HSE allocated the necessary funding to develop the Cashel site. The subsequent return of the INO union to the negotiation table, however, quickly resulted in another challenge to the amalgamation. The union adopted a position that all staff in Cashel faced disruption as a result of the merger and accordingly should receive financial compensation. The staff who had letters of comfort were being asked to move or face the disruption that would result from the transfer to another service (effectively change their jobs) and those without letters of comfort faced disruption from the transfer to Clonmel and the change to their home-life given the increased distances. This triggered a pay claim for compensation. The initial pay claim lodged was very substantial and this marked the potential for another set of long-term negotiations. The other unions in the Cashel hospital, covering the technical, clerical and other grades, indicated that they too would be seeking compensation for their members.

The announcement that money had been allocated to develop the services in Cashel also resulted in the re-emergence of another interest group. The Cashel Hospital Action Group, who had been dormant for so long, now requested meetings with the Hospital Manager to ensure that the exact services specified in the high court agreement of 1995 would be delivered into Cashel. This presented another potential blockage. Hospital services and best practice had moved on since 1995 and a debate about the detail versus spirit of the agreement began to emerge. The Cashel community more broadly began to take an interest and several misconceptions began to emerge, for example, the merger was decried by

a local politician and the Hospital Manager was 'summoned' to appear before the local council to explain what was happening. The hospital approach however was to engage the community in open dialogue and the Hospital Manager in particular made herself available to answer media issues and drive forward the strategic thinking about how hospital services for a better South Tipperary would emerge.

#### *7.4.3 Outcomes and Reflections*

The announcement of the funding to complete the Cashel campus post-merger marked the end of cycle 2. Substantial progress had been made on the accreditation front and the hospital community had increasingly homogenized many of its operating and procedural activities in line with best practice. The nursing union was back at the negotiating table and the nursing staff was attending amalgamation meetings once again. The re-emergence of the Cashel Action Group and the substantial pay claim submitted by the unions demonstrated, however, that much more work needed to be completed before the final amalgamation of services could be realised.

The end of cycle 2 presented a further opportunity to reflect on the progress and discuss what might be appropriate considerations for cycle 3. As part of developing our understanding of the events of the merger, the Hospital Manager and I had written a number of papers. One paper we had submitted to the Academy of Management Conference in Atlanta, US. The paper had been accepted and we decided to travel to the US. That conference has an active action



research community<sup>44</sup> and one of their annual workshops involved the action research community reviewing practice based research projects in a community setting, in an effort to develop both the projects and also the practice of action research. We submitted the hospital case as a potential for this workshop and it was accepted. We spent a full day, in the Academy workshop, discussing the case. This provided a substantial source of feedback and tested our understanding of our practice and of our thinking. The conference tested us on how we were working together and the relationship that we had developed; it also tested us on the way in which we saw other participants in the hospital merger broadening our understanding of how to engage ourselves and others. A clear learning that had emerged from our talking about the merger was the importance of leadership and bringing consultant groups, especially in Cashel on board more explicitly. This was possibly the first time we had explicitly spoken about our roles as a relationship of support. On the plane returning to Ireland we reflected on what we set out to achieve in terms of outcomes for the hospital and for my research. We realized that as time had passed our interactions had changed and that the extent to which we ‘bounced ideas’ off one another had increased. I recognised that I had played the role of process facilitator and expert but was less in tune with the role of personal support within the change activities that I had began playing. Similarly, my co-researcher conceived the relations in terms of trust and the increasing levels of trust that emerges over time as people work closely together. We had both found the workshop challenging and both recognized that we needed to codify our relationship more explicitly. My co-researcher codified her requirements as seeking help both in terms of the process of change and in

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<sup>44</sup> This workshop is run by the Sustainable Practice Action Research Community, SPARC <http://view.fdu.edu/default.aspx?id=4352>

terms of professional support. We discussed professional support as meaning the ability to explore ideas together and to provide constructive comment. For my part I wanted the depth of insight that came from being close to the issues and recognized the importance of the additional insights that emerged from our ability to be frank and direct with each other.

#### *7.4.4 Working with Co-researchers in Cycle 2*

This section sets out how the collaborative relationships operated and developed throughout the second cycle of action and reflection. There were few executive meetings during this period given the industrial relations issues. However there were numerous meetings between me and the co-researchers. Our primary concern was that the progress had been halted and we feared that the momentum gained would be lost. At the start of the cycle we discussed extensively why Cashel felt alienated and considered events and individual motivations as potential causes. Clearly there were a number of events that impacted the staff withdrawal. We had already begun to think in terms of the two Cashel groups as separate and distinctive and had discussed what this might mean (see comments in section 7.3.4). We were aware of the huge significance that the staff in Cashel placed on what was happening in Cashel post-merger and while we were disappointed that they had withdrawn from the amalgamation process we could understand the importance of the issue to them. The Integration Manager summed it up during one discussion when she reflected that it is the one issue that has constantly been on the table since the beginning of the amalgamation. Our discussion led us to realise that the funding for Cashel while outside of the



hospital's control was a central driver for the amalgamation and the Hospital Manager redoubled her efforts over this period to deliver the funding resource.

We were also aware that the huge momentum that had developed could be easily lost and we accordingly discussed how to leverage the gains that had been made to maintain some forward motion. We discussed what had worked well such as the team work and partnership structures at the centre of the processes. We observed that it was necessity that often acted as a key component in driving teams to realise their goals. When something had to be done, i.e. a common procedure for nursing practice, or the elimination of a clinical risk, it was engaged and completed. This strengthened our assumption that staff would work out the issues themselves if given an appropriate framework. The professional standards and pride in the service provision propelled staff toward achievement and we discussed whether this could be harnessed to help continue the drive toward amalgamation. The context of health provision was also changing and smaller hospitals like STGH were increasingly in danger of losing services. Clinicians and staff were aware of this issue. The co-researchers in particular shared thoughts around whether there was an inevitability about the merger, not because of the instruction to merger, but because STGH could not continue to support the existing structure within the emerging national health environment. We again uncovered an assumption and questioned whether we could assume people understood this reality. This led to us to question whether we needed to communicate this to a greater extent and possibly in other ways. This realisation helped us to develop the strategy used throughout this period. The merger was a natural progression of the hospital's service provision and it needed to continue

to drive best practice models in order to achieve adequate service provision rather than as a result of the merger. This was also clear in new quality obligations such as accreditation that were emerging nationally.

## 7.5 Cycle 3

### 7.5.1 *Diagnosing the Problem: the Drive to 'Merger Day'*

The reflections on the outcomes of the two previous cycles and the discussions that had occurred at the Academy of Management workshop identified a number of key tasks that had to be delivered if the amalgamation was to be completed:

1. Communicating to all groups the value and the importance of the merger in terms that they valued was critical.
2. Involving all of the different interest groups was essential. This involved the creation of new channels of communication, to the Cashel community, to the Hospital Action Group and to the staff who would remain in Cashel post-merger.
3. A clear target date needed to be established to focus minds and the actions of the working groups.

Reflecting on these tasks the third cycle of action would have a simple objective,

1. amalgamate the services.

This was translated into a number of management actions that included:

1. A concerted drive from the Hospital Manager to engage all groups and address all issues as promptly and effectively as possible;



2. Increasing range and number of actions that serve to integrate and homogenize processes in line with the boundary framework;
3. Involving the Cashel post-merger community, at the earliest stages, in the development of services in Cashel.

In boundary terms this represented an attempt to expose boundaries and bring them into contact with one another, exposing, where possible, potential conflict. By uncovering and recognizing potential boundaries they could be addressed and resolved before any damage could ensue.

#### *7.5.2 The Action Phase*

The discourse was changed in the management team to create a focus on ‘merger day,’ the date on which the actual transfer of services would take place. A new partnership group was established to discuss and agree the issues around the Cashel campus and to empower those who would remain. The Hospital Manager commenced regular meetings with the Cashel Action Group to keep them both informed about and involved in the decision making regarding Cashel. She also started to work more closely with the Hospital consultants to ensure their buy-in and support.

By September 2006, the tide was beginning to change. The executive transfer team had increased the frequency of their meetings. The sense that this merger process would be completed was emerging among all levels. Moreover, an impetus for the change was beginning to develop from the ground upwards. The accreditation process had demonstrated clearly the need for better facilities. The

lack of investment in maintaining the older facilities in Cashel meant the facilities were deteriorating at a rapid pace. Changes in health care best practice (i.e. clinical directorates and risk management) continued to expose the clinical risk that existed from divided surgical and medical sites. By early October the consultants in Clonmel decided that the clinical risks could not continue and demanded the merger be completed in mid-November. The date may have been unrealistic but the signal gave strong impetus to the process.

The hospital management decided that it needed to establish a date for the merger, one that would be set in stone and could not be changed. On the 6<sup>th</sup> October 2006 the HSE formally announced the date of the 12<sup>th</sup> January, 2007 for the amalgamation. The press release referred to *a new modernised approach* and that the *merging of expertise from both hospitals will greatly improve the quality of care provided to the community*. The press release also spoke extensively of the Cashel hospital and that *the site of Our Lady's Hospital in Cashel is set to see the development of additional Primary, Community and Continuing Care services which will greatly benefit the local community and provide an enhancement to existing acute and non-acute services*. The announcement was made from the Chief Executive Officer of the HSE; the most senior national figure in the health service.

The formal announcement of a date gave a sense of realism to the transfer and encouraged staff to engage in a very real way. The executive transfer group met soon after the announcement and decided to restructure their practices, moving away from an agenda that emphasised physical and technical issues to one that



emphasised the work processes in the hospital. In this way each activity was assigned a sponsor responsible for delivery of the transfer within that area. The group also decided to meet more regularly, Thursday mornings before normal work hours, until the transfer was complete. Attendance at the meetings also improved and additional staff were willingly seconded. It was evident that the time to completion, approximately 13 weeks, was extremely short to deliver the transfer and that a tight planning schedule was needed to ensure its delivery. At the same time the intensity of staff exchanges, training, patient pathway delivery and administrative system redesign intensified. There was a natural fit between the amalgamation process and the accreditation groups' work identifying best practice and this allowed the amalgamation process to incorporate new designs and improvements into its process.

However, many issues still remained unresolved particularly in terms of hospital staffing levels. While the union's compensation claim was ongoing, no decision could be taken by staff on whether or not they would transfer to Clonmel. To do so would go against the union's instructions and would be seen as weakening the negotiating hand of the union. From initial figures presented by the union to staff substantial amounts of compensation might be involved and staff was expecting a good 'payout'. In addition the negotiation may have been seen as another means of delaying or preventing the transfer occurring. Clearly some people were contractually bound to transfer but others could avail of letters of comfort and make the decision to remain. Without knowing who would transfer, the staffing levels and skills requirements post-merger could not be determined.

### 7.5.2.1 The View on the Ground

As October passed the work of the executive transfer group and the staff generally progressed positively. Outstanding issues were being addressed daily and the complex tasks of organising the transfer were being planned progressively. The decision to make the 12<sup>th</sup> of January ‘Merger Day’ was met with mixed feelings on the ground.

Interviews with staff members in late November and early December (approx. seven weeks pre amalgamation) identified that the staff had a range of concerns about the amalgamation. Cashel staff still struggled with the reality that the merger would occur and felt that the timeframe set made the task difficult if not impossible. Indeed on merger day one staff member openly suggested to the Hospital Manager that Cashel staff felt that *it would not happen and that they felt they would put it off for a while longer.*<sup>45</sup> The interviews clearly demonstrated the perception that further delays could be possible.

*Since the date was announced and even though people accepted it initially people just thought that it would be moved out because January is so busy and there is normally so much going on (Cashel Administrator pre-merger).*

*For the last couple of years it went like this; March, June, September was the month we were going to come together, every year. Every year this happened. And then all of a sudden it's the 12<sup>th</sup> January. The nurses are still at the Labour Court trying to get whatever they are looking for out of it. People who are going haven't even got timetables.....personally we still don't know what we are going to be doing. The people going to Clonmel don't know the hours they are going to be doing. There's no timetables done up yet and it's only a month away (Cashel Support-service pre-merger).*

*I mean this is now over 10 years in the pipeline, It's 10 years down the road and I suppose I was always hoping it would keep going and that*

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<sup>45</sup> Comment reported by the Hospital Manager



*there would be no final plans put in place (Cashel Care-assistant pre-merger).*

Similarly questions also existed over the timing of the merger with a strong sense existing that it was not optimal to affect the transfer at this date. Staff felt that *“they [the management] haven’t really planned for it and the services going with it” (Cashel Patient-carer (4) pre-merger)* and that *“it’s not enough time to get a ward up and running and to get everything in place” (Cashel Patient-carer (7) pre-merger)* or that the merger would be better if additional time was available, *we need another few weeks because Christmas is in the middle of it (Cashel Care-assistant pre-merger)*. There was a sense that everything was wrong with the date and that really the transfer should not happen.

*I think it’s definitely the wrong month. It’s the worst time of the month, it’s winter time, Clonmel has always had the record of being totally overcrowded in the months of January and February with flu epidemics, chest ailments and what have you. I just feel that March/ April would have been better months (Cashel Care-assistant (3) pre-merger).*

*There are many good points and bad points to having the medical and surgical services under one roof, to have them amalgamated. But at the same time they have worked perfectly well up to now, I know there has been a few hitches but they have managed (Cashel Administrator pre-merger).*

Of course, the concerns raised were concerns that could be raised at any time of the year. The hospitals were continually busy, there are always significant events, Christmas, summer time, winter influenza, and so on. The fear that management had not planned for the transfer sufficiently undermined the whole activities of the previous three years. Of note however was that the debate had shifted from, “it will not happen” to “this is the wrong time for it to happen”. Linked to these comments was an emotional side of the staff who in many cases expressed *sadness on all our behalves here in the fact that the surgery is moving*

(Cashel Care-management pre-merger) with a feeling that *our hospital is being taken from us (Cashel Care-management pre-merger)* and a fear of *what are we going to do when it's gone (Cashel Support-service pre-merger)*. However, the Cashel community had not given up on the need to 'protect' Cashel from the loss of its services.

*I think how it has developed over the years and how the fight that went on early on gelled people together. Now we are 20 years down the road but still that group is together fighting to hold the services, to have something here on site. That linked them all for years and that link is still there. Now new people have come in but it's almost as if that foundation was there and everybody has built on top of it (Cashel Care-assistant pre-merger).*

A heightened level of uncertainty was also very evident in Cashel and this was supported by the interview data. Cashel staff had a perception that not enough information was being given to them. This was particularly relevant *as people are taking more notice now of what's going on and people are really starting to think about it and talk about it more and are even seeking information now because we have come to the point where we have to accept it and try and make the best of it (Cashel Patient-carer (3) pre-merger)*. However the actual levels of communications had been quite substantial and some leaders in Cashel recognized this fact.

*So although the place has been swamped with information and communication, it's nobody's fault that some staff will say that they don't know things, It's selective deafness and blindness because they don't want to know (Cashel Care-management pre-merger).*

However, reality was clearly changing for people as the prospect of merger day approached. Individuals were eager to assess the impact of the change on their position. Interestingly, the biggest concerns revolved around the work practices



and many of these were pending union agreement and related to the Labour Court discussions. The ability of management to offer solutions to these issues was therefore limited. Cashel staff did perceive that they did not have sufficient information.

*I feel I know nothing. I don't know what time I am starting work on the 12th January. I don't know where I am going to work, when I am going to know my hours, whether I am going to have a permanent job. I feel I know nothing, we are going to a new hospital and are we going to have car parking etc? I know the unions are still in negotiations but there is nothing laid down and you wonder then why people can't make decisions as to whether they are going to go or not! They have no information (Cashel Patient-carer (4) pre-merger).*

*For instance staff that have been working here for 15 years plus and there are quite a few of them actually don't know after the 12th January what they are coming to work to do. They have absolutely no clue whatsoever (Cashel Patient-carer (3) pre-merger).*

Contrasting with Cashel, the Clonmel staff were looking forward to the improvements in service, *I think it is great; I am really looking forward to it (Clonmel Patient-carer (2) pre-merger)* and the better patient care, *It will be good for the patient (Clonmel Patient-carer (1) pre-merger)* that would develop as a result. Clonmel staff did suffer from a level of uncertainty and realised that the transfer would not be without its problems *There are a lot of frustrating times ahead (Clonmel Patient-carer (2) pre-merger)*, and *I do not think it is going to be easy; it will be difficult the first day it happens (Clonmel Patient-carer (5) pre-merger)* but appeared more relaxed about the transfer.

*We really will not know until we are all in under one roof what is going to happen and how it is going to impact on some services. It is going to take a while for everything to settle down. It is not going to be easy for the first couple of months. ... I think in general it is going to be good. There will be some people that will complain. You will never convince them (Clonmel Patient-carer (2) pre-merger).*

*There is going to be a bit of an upheaval when it happens. It will be different in the beginning but it will settle down. There will be areas now*

*that we did not have before. It will be as if they were always here. Different people will have different problems with it but that is only natural. I think it will be perfect (Clonmel Support-services (3) pre-merger).*

Clonmel staff sympathized, somewhat, with the Cashel staff and realized the great change that it would involve for them coming over to Clonmel. Clonmel staff felt that the decision could have gone the other way and that they might, under different circumstances, have been the ones to move.

*I do have sympathy for staff in Cashel for them being disrupted. It has to be done and that is it. Unfortunately they are the ones that have to move but I still think that it is really needed. I am really looking forward to it and I think it will be good for the Southeast (Clonmel Patient-carer (5) pre-merger).*

*We are going to have to be a bit more tolerant of them in that we are going to have to give them time to adjust to the work practices. I do think people are going to understand. It could have happened either way. People are going to think, "Well it could have been me moving" (Clonmel Clinical-care (3) pre-merger).*

*I think it was perceived for so long that it wasn't going to happen, the dates were being brought back for so long. I think they thought it would never really happen....I suppose there were hiccups the whole time with people pushing it back, either staff relations or just issues that could not have been helped.....I would say they got a shock with the date. They all thought it wasn't coming (Clonmel Administrator (1) pre-merger).*

Overall the Clonmel staff felt that the merger was necessary and that the service improvements were necessary to *regularise the hospital (Clonmel Administrator (2) pre-merger)* and to eliminate a *huge deficit in services down through the years (Clonmel Patient-carer (4) pre-merger)*. At the end of the day the amalgamation was for the *safety of the patients (Clonmel Clinical-care (3) pre-merger)*.



The position of the two staff groups clearly shows the fragility of the position in the two hospitals pre-merger. Cashel had concerns about the ability to merge and had high levels of uncertainty (as might be expected). These offered conditions that could easily be translated into further action against the merger (e.g.. the timing is impossible) or against the Clonmel group (e.g. they weren't being treated fairly). In contrast Clonmel wanted the merger to occur and while sympathetic toward Cashel they wanted the merger to be finalized without any further delays.

#### 7.5.2.2 Realising the Merger

The major driving force for delivering the merger was the executive transfer group under the chairpersonship of the Hospital Manager. The Hospital Manager was the central figure, to whom all parties looked for leadership and direction. She took responsibility for ensuring the key issues that needed to be resolved, remained on the agenda, and tirelessly negotiated with the various parties. At this point the major issues that needed to be resolved included

1. industrial relations, primarily compensation payments to staff transferring;
2. the Cashel Action Group's desire to deliver the exact terms of the high court agreement (and their threat to seek an injunction against the transfer if their demands were not met);
3. the politicians in Cashel and their perceived loss of service;
4. the Consultants' and Surgeons' position on beds and sharing of services and resources (for example the surgical ward wanted to ring-fence their beds) and

5. the clinical risk issues of ensuring that the transfer process was properly planned and executed with adequate capacity to run the hospital post-merger.

Of these issues the industrial relations and the Cashel Action Group presented the largest potential risk to not delivering the merger deadline. The executive transfer group was now meeting on a weekly basis with each of these key issues closely monitored. A strong multiple level communication process was implemented with strong media outputs (for example newspaper advertorials in local papers laying out a vision for Cashel and regular radio appearances by the Hospital Manager in response to politicians' statements) and visible symbols of progress (and the transfer) in Cashel, for example the erection of a billboard displaying the new hospital services for the people of Cashel.

Operational issues remained unresolved including, among others, starting times, theatre times, record management, storage space, on-call duty, directional signs in the hospital, unifying the bleep system and staff identity cards. Partnership groups directed by the operation transfer team were established to resolve these problems and in this way the decision making for operational issues was delegated to those most closely affected by the change. Each unit/department in the hospital was also requested to develop departmental transfer plans which helped to identify issues that would emerge in the transfer, including location of ancillary services, storage and even simple process issues such as portering arrangements.



A key challenge was ensuring that the appropriate number and experience of staff would be available to the hospital post transfer. Until the unions and their staff agreed to a compensation package staff could not formally confirm whether they would be willing to transfer to Clonmel. Accordingly, there was no clear indication of the post-merger staffing until the compensation was formally agreed on the 2<sup>nd</sup> January 2007, only 10 days before the merger. The agreement of the unions was reached only after extensive Labour Relations Commission<sup>46</sup> meetings and a series of offers and refusals. The Hospital Manager and the Director of Nursing endeavoured to maximize the number of staff that transferred (even if only for a fixed period post-merger) and the Director of Nursing recruited widely from other hospitals. The final numbers transferring however were lower than optimum and some beds remained unopened in the initial stages of the post-merger period.<sup>47</sup> The skills mix of staff also provided problems as many of the more senior staff remained behind in Cashel.

Another function of the executive group was to ensure that the incoming staff from Cashel was orientated to the hospital and its layout. There was a clear need to train and brief all staff both on the transfer and on operating procedures. A planned phasing down of activity in Cashel was scheduled and one ward was to be closed a week prior to transfer to facilitate the training and orientation of staff transferring. The executive group also spent substantial time addressing the

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<sup>46</sup> The labour relations commission is a formal part of the state's machinery for resolving industrial relations claims.

<sup>47</sup> An interesting aside was that the issue of staffing levels in a post-merger hospital arose some months after the STGH experience when three maternity hospitals moved to a newly built state of the art facility. The transfer was delayed for three weeks when at the very last moment the nursing unions withdrew from the transfer because they were unhappy with the levels of staffing and insisted that new staff be appointed.

needs of Cashel post-merger. The inclusion of representatives of the PCCC<sup>48</sup>, the organisation which would have responsibility for the management of services once the transfer had occurred, strengthened the link between the pre- and post-period. This was helped by leaders in Cashel, particularly the Director of Nursing, who recognized the challenges of post-merger structures in Cashel and rose to the challenge of developing a vision for the services. In addition the Hospital Manager met the Cashel Action Group regularly and while some issues were complex to resolve, a final agreement on the level of services remaining was negotiated.

This period of the merger process was not a smooth one and was punctuated by periods of strong resistance by the various groups. For example, resolving the industrial relations issues involved two Labour Relations Commission interventions and substantial management-union negotiations. The Cashel Action Group threatening to take out an injunction up to the last week of the merger and the Hospital Consultants through their representative body resisted the loss of beds and went public with a media campaign immediately prior to the merger.

### *7.5.3 Outcomes and Reflections*

If the week leading up to merger day (as it now had become referred to within the hospital communities) was traumatic and problematic (it was described by the Hospital Manager as possibly one of the worst in her life) then merger day itself was the exact opposite. Early on the morning of the move a fleet of ambulances arrived at the Cashel Hospital and began the process of moving

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<sup>48</sup> Primary, Community and Continuing Care is a division of the HSE with responsibility for managing these services.



patients. The hospital had reduced its activity and luckily had no emergencies the previous evening. In total only 17 patients had to be moved. The transfer of patients was completed in a couple of hours although the movement of equipment took all day. Staff in Cashel described the event as emotional and felt a huge sense of loss as they watched the dismantling of the hospital and the transfer of its equipment and people over to Clonmel. One informant summed up the day:

*The biggest thing that will stick in my mind is the morning it happened and at 7:45am I went into work and there was four ambulances and probably 10-12 ambulance people standing outside the door ready to literally run and pick the patients. It was like something you would see on the TV where you have a minute to shop! (Cashel Patient-carer (5) post-merger).*

In Clonmel the patients were received and processed to their new location quickly and without incident. The transfer was publicized widely and celebrated as a big event for the future development of the hospital. Local media were on site to record and report on the transfer. A huge electronic roadside notice-board was hired for the front of the hospital and it flashed out the message..... *historic day for sth tipp with union of acute services*. Welcoming banners were placed in the foyer of the hospital. Free tea and scones were available and Clonmel staff brought sweets into the Cashel-staffed wards as welcoming gifts. The day passed off without incident and the merger of Cashel and Clonmel Hospitals to create a full service general hospital, South Tipperary General Hospital was finally realised. At the end of the day the Hospital Manager was text-messaging the short message *'all systems go.'*

#### 7.5.4 *Working with Co-researchers in Cycle 3*

This section sets out how the collaborative relationships operated and developed throughout the third cycle of action and reflection. The nature of the executive transfer team meetings changed during the course of this cycle. The meetings had traditionally focused on the key themes and reports from the operational structures such as industrial relations, capital development and so on.

Discussions with the co-researchers in September 2006 however, started to focus on the actual amalgamation date and how we might best structure the process to deliver optimal outcomes. We started to talk about a number of issues and assumptions. Firstly we were aware that we needed to create buy-in among a number of people and we needed to engage them as much as possible. We had learned that not all staff felt included in the first cycle of communication. The co-researchers communicated extensively with staff in that cycle but our reflection concluded that we had not fully engaged the reality of the staff as they saw it, i.e. we spent too little time on the Cashel problems and as a result they did not engage other communications. This challenged our assumption that telling staff what was happening was a sufficient communication and we grew to appreciate the need for more focused communication that was tangible and symbolic for staff. This was described as the need for ‘tangible proof’ by one of the co-researchers. The Hospital Manager engaged this theme in a number of ways. She ensured symbols of the merger would be displayed; these included for example the announcement of the merger date by the highest ranking officer in the health services and the erection of a large public billboard in Cashel that showed how the building would look post-merger by displaying a picture of it and listing the



services that would be available in it. Secondly, we questioned the extent to which the existing level of participation and engagement was sufficient to impact on all staff. The partnership structure had worked well and would continue, however we began discussing whether the partnership structured allowed some staff to abdicate responsibility or awareness of the merger because it was the responsibility of the partnership group. We decided to surface this assumption in the executive transfer group. We raised the issue in a subsequent group meeting and the group engaged with a debate on the need for clear responsibility to be assigned to individuals to ensure that departmental relevant tasks were completed. The group then decided that the key activities for each part of the amalgamation process would be identified and a named individual would be given responsibility. Eleven groups were established that covered clinical areas, nursing technical services, communication strategy and so on. Each group was required to engage with all staff within their allocated area and to develop detailed transfer plans in combination with the partnership group. This new structure became a strong symbol for the impending merger and represented a participative change process that dealt with our fear of staff not engaging. The role of the executive group also changed from supporting the partnership groups to driving system wide engagement and change.

The need for symbolism became a substantial part of the discussion within the researcher/co-research group as this cycle unfolded. We were conscious that earlier attempts had failed because an anti-change agenda had gained weight. In discussions we wondered why this had happened and looked to explain it by reference to powerful groups or key change agents that were opposed to change.

This was an assumption that there were organised forces for resisting change and that in some way by engaging them we might reduce that resistance. However as events unfolded we encountered a number of unanticipated events that supported change indirectly. For instance problems in the theatre in Cashel created a fear that the theatre would need to be closed, this re-enforced the need for the transfer. Similarly, the impending accreditation process began to highlight clinical risks. These symbols helped the Hospital Manager engage people and we began to consider that it was not purely resistance to change that was driving anti-merger sentiment rather it was people may not be accepting either the reason for or the sense of supporting the change. This helped us to re-conceive the final merger push as a symbolic activity and that we needed to align all the symbols that reinforced change. This involved communication extensively and publicly (local advertorials) as well as engaging everyone (internal and external) in the process.

## **7.6 Cycle 4**

### *7.6.1 Diagnosing the Problem: From Amalgamation to Normal Operations*

The final cycle of action aimed to evaluate the merger in terms of the cycle 1 objectives that were initially established. It was important that the amalgamation process was deemed completed and the good practices developed throughout the period of the merger were properly integrated into the operating ethos of the hospital (to achieve double-loop learning and sustainable changes in practice). The executive transfer group had affected the transfer and the two hospitals now operated on one site. The overall objective of the transfer required that this



physical co-location was matched by effective integration mechanisms that avoided a ‘hospital within a hospital’ emerging. The final cycle therefore set a number of objectives:

1. Continue to support the executive structure as appropriate and to ensure any emerging [boundary] issues have a conduit through which they can be resolved;
2. Continue to build identification with STGH and common values among staff;
3. Evaluate the level of integration achieved;
4. Migrate outstanding issues to the normal operating and responsibility structures of the hospital.

#### *7.6.2 The Action Phase: Normalizing Operations*

The executive transfer team continued to meet after the merger to identify and resolve issues, most of the issues were operational in nature and the operating transfer team was able to deal with them. The staffing issue had, however, worsened and significant skill shortages existed in some areas. The Director of Nursing was recruiting as aggressively as possible but staff slippage started to occur as staff took career-breaks, went on maternity leave or took up positions elsewhere or in some cases returned to Cashel. Increasingly the executive transfer team’s need to meet lessened and it was disbanded in early February. Issues and conflicts were emerging, particularly around medical records and staffing levels, but these were being addressed head on by the line managers responsible. Issues became the responsibility of the line management and moved away from the responsibility of the amalgamation team.

The hospital formally launched the mission statement in March 2007 and held formal celebrations to acknowledge the new STGH. Throughout this period the accreditation programme was moving to centre stage and the date for the accreditation review was set for April 2007. This served to help staff focus on a unitary purpose and to work toward process improvement. However in March 2007, the industrial relations environment was again to cause problems for the hospital. A national pay negotiation about nursing pay levels reached an impasse and the nursing unions issued a national work-to-rule directive. This affected all hospitals and STGH was strongly impacted and had to reduce services and defer the accreditation programme. However, the relationship between the management and the union concerned remained strong throughout the industrial action.

### *7.6.3 Final Outcomes and Reflections*

The final stage in the action research was to assess the final outcomes that were achieved. The ending of the nursing dispute in June 2007 allowed us to apply a hospital-wide questionnaire to assess perceptions of the staff on how the hospital had progressed. Six months had passed since merger day and some problems still existed, particularly in terms of staffing but the day-to-day operations of the hospitals had developed smoothly and the hospital appeared to be working together as a unified and integrated organisation. Because the questionnaire was applied after the nursing work-to-rule it was expected that some negative sentiment would be experienced. Overall, however, the results of the questionnaires were more positive than expected.



Reflections on the process to this stage and on the needs of the accreditation processes had led management to conclude that a regular annual questionnaire to all staff would serve as an ongoing and sustainable way of feeding staff perceptions into management decision making (see section 4.3.4.3. and appendix 10). In total 997 staff received a postal questionnaire directly to their home address as recorded in personnel. The response rate was 36.7% and a cross-section of the hospital community was represented in the replies.

Table 7.6 reports the questionnaire findings on a number of questions that relate to the level of integration achieved and the perception of success of the merger. The results indicated a positive outcome of the merger with a total mean score of 5.11 over the full hospital community. Looking at differences in perception between Cashel and Clonmel staff<sup>49</sup> (3.91 to 5.39) indicates differences in perception but that the Cashel outcome still tends toward the positive. Similarly all the groups seem to feel that the hospital had moved on from the amalgamation (amalgamation complete = mean of 4.83), that the hospitals have integrated well (operate as one hospital = mean of 5.35) and work together as a team (mean = 4.85).

Comparing the levels of identification (table 7.7 and 7.8) over the two periods also shows some interesting shifts in the hospital make-up. While staff from Cashel reported low levels of identification with STGH pre-merger this had

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<sup>49</sup> This definition is problematic as when the merger finally occurred it was difficult to define precisely which was the hospital of heritage and many staff referred to themselves as STGH (and they could have been located in Cashel, Clonmel or both). The data shown is based on self-rating (who was your contract of employment originally with).

shifted to a much higher level post-merger. The scale’s Cronback’s alpha of 0.948 allowed the scale to be collapsed into a single three point measure and on this basis all hospital communities identified with South Tipperary General post-merger.

Table 7.6: Scores on integration measures June 2007

Question	Cashel		Clonmel		STGH		Total	
	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev
The amalgamation of services at South Tipperary General has been successful	3.91	1.667	5.39	1.545	5.46	1.305	5.11	1.592
The transfer of services is now complete	4.23	1.888	5.04	1.628	5.03	1.683	4.83	1.745
I was well informed about the transfer of services and knew what to expect	3.65	2.092	5.03	1.792	5.16	1.758	4.76	1.946
The Hospital provides better services now than when the services were on separate sites	3.91	1.934	6.19	1.237	6.04	1.433	5.66	1.714
I am happy with the progress being made to date after the transfer of services	3.88	1.885	5.13	1.661	5.52	1.507	5.03	1.754
I feel I contributed to creating the new hospital	4.02	2.032	4.85	2.033	4.98	1.783	4.65	2.004
We operate as one hospital now rather than two separate hospitals	4.60	2.290	5.47	1.745	5.81	1.570	5.35	1.898
The staff from St Joseph’s and Our Lady’s Hospitals work together as a team	4.11	2.062	4.93	1.817	5.26	1.637	4.85	1.859
Our service continues to improve all of the time	4.29	2.034	5.40	1.572	5.64	1.529	5.24	1.731
We have achieved a high standard of service since the amalgamation	4.18	1.896	5.30	1.458	5.45	1.464	5.09	1.642

Statements were ranked on a scale of 1-7 where 1 represented complete disagreement and 7 represented complete agreement.

Table 7.7: Identity scores June 2007

Question	Cashel		Clonmel		STGH		Total	
	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev
I see myself as being from STGH	4.57	2.133	5.93	1.779	6.06	1.622	5.63	1.923
I am pleased to be a member of STGH	4.76	1.943	6.06	1.447	6.15	1.556	5.75	1.731
I feel strong ties with STGH	4.02	1.929	5.68	1.749	5.62	1.785	5.25	1.937
I identify with other members of STGH	4.45	2.008	5.85	1.617	5.86	1.670	5.50	1.835
Being a member of STGH is important to me	4.51	1.904	5.77	1.531	5.82	1.684	5.47	1.778

Statements were ranked on a scale of 1-7 where 1 represented complete disagreement and 7 represented complete agreement.

Table 7.8: Identity scores (collapsed scale) June 2007

	Cashel		Clonmel		STGH		Total	
	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean	Std Dev
Identity	2.20	0.989	2.82	0.555	2.84	0.975	2.69	0.716

Statements were ranked on a scale of 1-3 where 1 represented disagreement and 3 represented agreement.



#### 7.6.4 The Views on the Ground

The questionnaire data suggested that the merger had been completed successfully and that broadly there was a level of satisfaction with the outcomes. Interviews conducted with staff six months post-merger showed a mixed set of feelings toward the merger. Broadly, individuals did perceive that the patient care environment had improved, *working together makes things much better and easier regarding patient management and quality of care (Cashel Clinical-care post-merger)* and the progression of the hospital was positive, *when I look at what we have done we have achieved a lot in six months. I think people are surprised that it functions so well you know, that we are seeing so many patients and that we are processing so much (Cashel Patient-carer (1) post-merger)*. Overall, the general perception supported the questionnaire data, *from our end of it I could not think of anything that has not worked well (Clonmel Support-services (2) post-merger)*. Having said this, there was also a very strong sense that the transition had been traumatic and had been a challenge for people.

*It has been a difficult transition and I think it is starting to settle down a bit now. It was actually a lot harder than I thought. I thought that once it arrived we would just get on with it and it would all gel together. It was actually harder on the people here because it actually impacted more on the people who were here than on the people who came over. They were kind of expecting it and were kind of built up for that whereas kind of here we just wanted them to come and it had a bigger impact here (Clonmel Patient-carer (2) post-merger).*

*I haven't reached that stage yet [belonging to STGH]. I don't have the same dread I had walking in the door as I had say up to the end of February. Where I just thought there were so many things to be fixed and so many issues to be solved that I just wanted to just run away. I don't have that feeling anymore. I'm OK coming in the mornings (Cashel Patient-carer (2) post-merger).*

*I do think it is running [the hospital]. It is running. It is not running smoothly all the time. But it is running ..... The whole move has gone well. We didn't think it would. I don't think anything has gone*

*wrong I am just talking about little hiccups (Clonmel Administrator (3) post-merger).*

Notwithstanding the positive positions generally expressed there still existed strong beliefs that the position, especially that of Cashel staff, had not improved or indeed had worsened, *I can't really think of anything that worked well. I just thought it was horrendous (Clonmel Administrator (2) post-merger).* Others had a more moderate view suggesting that series of 'ups and downs' would be a necessary part of settling into an effective operating system.

*Yes we are six months in and we are here. I feel that the amalgamation was stormy. I feel that we still haven't achieved what we should have had from day one. There are still outstanding issues with regard to clinical expertise coming to the units, with regard to storage, technical issues and building issues that should never have happened. It should never have been the case that we moved without these issues being resolved. We are in a new building but with the exception of a couple of things like cardiology availability we are no different than we were in Our Lady's in Cashel (Cashel Patient-carer (2) post-merger).*

*I suppose it seems longer than six months in some ways and yet it is kind of hard to believe it is that length of time. I feel it has achieved a lot on a lot of levels but I think there is more work to be done. I think there is plans in place to be finished off and it was a very stressful time, it didn't turn out to be as smooth as I expected. I feel anyway (Clonmel Patient-carer (5) post-merger).*

Reflecting on the data collected through the interviews and the conversations on the ground between the hospital team and the staff, the hospital management in October 2007 concluded that the post-merger phase of the amalgamation had been completed. Unresolved issues remained around staffing and resources but these were issues that are normal parts of the hospital operations. The accreditation process was still moving apace and a date for the review had been set for December 2007. This review would establish a new chapter in the life



history of the hospital and it was appropriate that any residue of the amalgamation process did not carry forward into that chapter. A clear target for performance in the accreditation process had been established by management (a target above the performance level of many other hospitals) and all the focus of staff was clearly directed at achieving this outcome.<sup>50</sup>

The final reflections on the amalgamation led management to nominate the transfer teams for a national health sector service award for change management. The management team was eager to codify the learning from the process and to share it widely. A large representative group came together to agree the presentation for the assessment review, and discussed the practice of what they had done and the critical successes that they had achieved. There was strong recognition of the leadership shown in the hospital and the resilience to maintain focus in the light of the challenges to the merger. The importance of the action research cycles was acknowledged and the need to be able to act and reflect in cycles seen as a key means of responding to the complex and ever-changing environment that they encountered. The presentation the team made emphasized the history of the transfer and the perceived impossibility of the task; it spoke about the task challenges and the involvement of all the staff in the process. The Hospital Manager emphasized the role of trust and trust building as a critical component in the engagement of the staff. Finally, it recognized the need for a clear change model, the value that the action research cycles provided and above all the importance of strong leadership. The presentation was made by a strong cross-sectional group from the hospital. In the competition, the hospital was

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<sup>50</sup> The review took place on the week commencing 4<sup>th</sup> December 2007 and the hospital achieved its targeted level of accreditation

awarded a special merit award for its achievements. This was final recognition of the success that had been achieved in a complex amalgamation process.

#### *7.6.5 Working with Co-researchers in Cycle 4*

The final cycle of action was designed to embed the gains achieved in the amalgamation. The executive team was disbanded and the reflection and discussion among the researcher/co-researcher group moved to trying and explain what had happened. These reflections were more to do with the academic research that with merger integration action. We had discussed what success meant and how we would measure it and had lengthy debates about the risks associated with formally assessing the outcomes (see section 7.7). I produced a draft of this dissertation and presented it to my co-researchers and we spend three meetings and approximately three hours discussing our reflections on the process. These reflections represent the discussion presented in chapters 9 and 10.

### **7.7 Challenges in the Role of Action Researcher**

Section 3.6.1 outlined the challenges that exist for action researchers in determining the role they play within the research collaboration and in recognizing the dilemmas that might arise in the course of the research. The principal role being promoted was that of process facilitator aiming to develop relationships that helped the hospital to make informed decisions. The design hoped to deal with issues of ethics and politics and role definition through the early codification of roles and processes of engagement (see appendix 2 for the letter of engagement) that fostered dialogue between me as action researcher and



my co-researchers.<sup>51</sup> This section sets how the relationship between us worked and how we engaged the challenges that emerged in the process based on the research design.

The letter of engagement clearly laid out the expected roles of the action research project. I was engaged in research, pursuing a doctorate, as the primary aim of the work and undertaking to adhere to best practice in the execution of that research. In contrast STGH viewed the research as a bi-directional activity that would 'improve practice' at the hospital. I would become a member of the executive transfer team and through that team foster learning about change generally. In practice the execution of the research took a slightly different direction. The initial hope that the executive team might be a reflection group shifted as the pattern of meetings and engagements took shape over time. From early in the amalgamation process I started to meet with key hospital staff, both individually and collectively. Of particular importance were the Hospital Manager, who was the strategic driver of the process and the Integration Manager who was the operational driver of change. These two people became my close working colleagues for the amalgamation and the reflections on it. They were the key decision makers. Given that these two managers worked closely together, we quickly fell into a pattern of an independent tri-party relationship in which we meet more often as a pair than as a triad. In total I noted 20 individual meetings with the Integration Manager, 13 individual meetings with the Hospital Manager and 9 collective sessions where we met as a group. Where significant reflection and decision making was needed we tended to meet

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<sup>51</sup> Co-researchers is used as a collective term to mean, the Hospital Manager and the Integration Manager

as a group, for instance the final planning stage for the amalgamation or the final reflection session to complete the action research. This network of relationships worked well as there was an open and fluid approach to communication. Possibly a help to this working relationship was that I often wrote text around our endeavors, particularly conference papers, and shared them with both parties. Similarly, the Hospital Manager wrote specific articles and by nominating the hospital transfer groups for service awards (which involved the full transfer team preparing for the award) opened up our practice to both ourselves and to others.

The processes were not however without dilemmas, as might be expected. The early stage of collecting data on the context of the merger engaged me with a diversity of staff and allowed early relationships to be developed with key players especially the Integration Manager. The executive transfer group was established in June 2008, six months after I had commenced engaging the hospital. Throughout the early period of diagnosing, I increasingly engaged with the Integration Manager and Hospital Manager; they were the key decision makers and the key people who were seeking support in relation to merger activities. For instance, early discussions on communications highlighted the need for an integration newsletter to be published. I was asked to help and advise on the content and style of the newsletter. This was not strictly within the remit of the research agenda, but there was a clear need for a helping intervention. This was not totally a process consultation intervention but more like expert advice. Conscious of my role to help foster individual and organisational learning I provided samples of previous merger integration newsletters as practical guidance and offered to review and edit as appropriate. In this way I became both



a sounding board, for questions such as is it a good idea to include this item, and also a resource, for instance in writing or editing some of the text. Here was a clear dilemma that moved me beyond the stated role of researcher to be more prescriptive with my co-researchers. This dilemma arose several times throughout the research when the hospital management requested that I conduct activity outside of the core remit of the amalgamation process. Other examples include the development of the mission statement and the accreditation process where I crossed over from researcher to expert. Part of this crossing-over was related to legitimacy. The hospital wanted to ensure processes stood up to external evaluation and accordingly needed 'expert' input. By co-opting me, a local academic, to certain committees these legitimacy needs were met. I was conscious of this and recognized the dilemma of the shift in status but this was juxtaposed against the additional information and relational access that emerged from engaging the additional assignments. I attempted to mediate the dilemma by clearly defining the roles as separate, usually through re-negotiating my relationship with the hospital for that activity. For instance I mediated the mission statement development by engaging another person to physically conduct the focus groups and this person received pay directly from the hospital. Similarly for the accreditation process I became entitled to expenses for attending meetings. In this way I separated the research activities and how they were discussed from additional activities.

Another dilemma arose from the data collection stages and the potential conflict of seeking data for research purposes and the potential for that data to be misused to the detriment of the hospital. Of particular concern was evaluating how the

merger was perceived by staff. I wanted to know whether staff felt that the merger process was effective and whether the post-merger hospital represented an improvement over the pre-merger state (we all agreed this would be worthy data for planning purposes). Furthermore there was a need from the hospitals perspective of assessing the level of staff satisfaction about the hospital merger. I felt that the data were important both from the hospital and research perspective but I was aware that it satisfied my needs to a greater extent than the hospital needs. I was also acutely aware, however, of the political macro-environment of the health services and the potential for this data to be used as political means to undermine the hospital's progress. I decided that the dilemma might be resolved through open dialogue with the Integration and Hospital Managers. We discussed the benefits of including direct questions on success in the questionnaire data collection and the downside of receiving negative sentiment.<sup>52</sup> I was somewhat surprised that my concerns were not as strongly held by my co-researchers who recognized the need to create an evidenced based conclusion to the amalgamation process. They acknowledged that if our perceptions of success were in error then we would have to resolve issues either now (through this cycle of data collection) or in the future as problems arose. In the end the data pointed to a successful outcome.

A final issue that arose within the action research related to the trust and support that I had with the co-researchers and the implications that that had for publication and dissertation writing. Given the extensive nature of the working relationship strong mutual support existed throughout the research team. The

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<sup>52</sup> i.e at meetings on 18<sup>th</sup> April 2007; 3<sup>rd</sup> May 2007 and 11<sup>th</sup> June 2007.



research spanned over 4 years of cooperation and through that time we, as a group and between us as individuals, built a practice and history of mutual support. It was this relationship that helped in what the Hospital Manager referred to as 'our brainstorming' where we openly discussed issues in radical and open ended ways so that we could explore new spaces in a comfortable environment and generate new avenues for testing our understanding. This building of trust and comfortable context however also creates potential dilemmas. As trust and openness builds, the divide between private comment and reportable reflection becomes blurred and a risk that we become comfortable in our own engagement and less aware of the wider political implications of our statements can emerge. This came to light in one episode when I had written an article for a conference (O'Byrne et al, 2005) and presented it to my co-researchers for comment, which they duly did. It was only sometime afterwards that the Hospital Manager commented to me that she had not given enough thought to the perceptions of others to what had been written, especially others in the hospital. While there was no issues in what was written the insight is important in its own right. Linked to this was my own problem in ensuring I did not mix private and public comment. The main mechanism through which this was achieved was involving my co-researchers in the writing review processes. All writing was presented to them and I ensured that writing occurred throughout the project so that regular updates were available.

## **7.8 Conclusion**

This chapter has set out the story of the hospital merger describing the tensions that emerged as the drive to merge the hospital ebbed and flowed between

success and failure. Strong forces of resistance legitimized the need for separation at key junctures while supporters of change concentrated on the clinical and risk necessity of merging. The narrations show how the action research approach facilitated learning with interventions changing as assumptions were challenged by unexpected outcomes. The next chapter will develop the study by analyzing the boundaries that existed in the hospital and by comparing those to the financial study. Replicating the same boundary types gives strength to the theory developed. The story of the hospital shows the value of the framework for designing and implementing interventions to support new boundary formation.



## **8 The Analysis of Boundaries in the Hospital Study**

### **8.1 Introduction**

This chapter and the following chapter address the third pillar of the research design by developing theory in practice. It explores the boundaries that existed in the hospital and how they changed during the course of the merger. The chapter has the following objectives:

1. establish the boundaries that potentially existed in the case with particular reference to the boundary model developed in the financial studies case;
2. explore similarities and dissimilarities between the financial studies and hospital studies.

The chapter draws on data collected through 38 structured interviews to provide additional data on the boundaries identified in tables 6.4 to 6.6. Using the framework (table 6.8) in practice allowed the informants to be asked more directly about each boundary and to explain potential differences more directly. This is consistent with the purpose and objectives of this phase of the research which is to test the relevance of the categories rather than expand on them. Data was collected on other boundaries but no additional ones emerged from the interviews. The chapter also reports perceptions of staff both pre- and post-merger.

The hospital closely mirrored the financial study in the types of differences between the two groups. Some variations existed in respect of the types of work

that characterise a hospital and a financial services firm, for example a nurse and a financial clerk will interact with technology and computer systems in very different ways but nonetheless the analysis shows that the boundary categories have relevance even if slight variations in their work application exist.

The output from this chapter will provide support to the framework developed in chapter 6 and will give context to the issues of boundary change within the hospital as a prelude to a discussion on boundary salience. The following chapter can then address the issue of boundary salience.

The chapter is written as a data chapter laying out the data and opening up the data to allow the reader to see how the findings of the case have emerged. The discussion and analysis of the findings will be presented in the next chapter.

## **8.2 The Profile of Boundaries in the Study**

The following sections will explore the boundaries that existed in the hospital study discussing the pre- and post-perceptions of each group.

### **8.2.1 *Physical Boundaries***

Physical boundaries are tangible differences that have a physical manifestation.

As in the financial services study, these accounted for the largest number of identifiable boundaries and the category that staff most often cited as differences between the two hospitals. The financial services study identified seven possible physical boundary categories.

#### **1. Job description**



2. Product /services set
3. Location
4. Colleagues
5. Owners
6. IT system
7. Branch manager

One of these categories, owners, had no impact in the hospital study as there was no change expected in the ownership of the hospitals (all staff were employed by the state and they enjoyed status of public servant). The consistency of public ownership negates the use of the boundary category and as a result the category was not used in the coding. Similarly, there was no change to the overall management of the hospital. The existing Hospital Manager had authority over both sites and would continue as leader post-amalgamation. However, the line management in some areas was expected to change and given the increased size of the hospital, reporting structures were also affected. This category was accordingly changed to reflect changes in leadership within the individual unit or area. This is consistent with the financial study as the branch manager was also the direct line manager of the staff.

#### 8.2.1.1 Job Description

Job description was defined as differences in the terms and conditions of employment for each group. There was substantial difference in the two hospitals' terms and conditions notwithstanding that each group had the same employment contract with the HSE. These differences concerned customs and

practices that had developed over the years in each hospital, for instance, major issues included starting times, requirement to do on-call duty and job flexibilities. In addition there were a number of general routines and artefacts that also created potential problems, such as uniform policy, secure car parking and canteen facilities. Some perks also existed, particularly in Cashel, such as free brown bread with morning coffee. The potential problems in working conditions were explored early in the amalgamation process with the Integration Manager discussing the issues with staff and creating a list of '*issues of concern*'<sup>53</sup> which subsequently formed the basis for the work schedules for the partnership working groups. Even though many of these issues were resolved as the amalgamation progressed, there still existed some concerns and potential for boundary conflicts to develop.

The most obvious concern emerged from feared changes in the work practices of staff. For instance, the multi-tasking that occurred in Cashel because of the lower numbers of staff (everyone had to multi-task) was being replaced with a more formal system of job specifications and defined specialism. There was also a fear that the work would be more directed than in Cashel. The view from Clonmel pre-merger was similar. There was acknowledgment of the differences in the working environment that would impact on the working conditions of staff.

*Well any of my mates moving are absolutely dreading it. There is one guy who would be younger than me and he hates the thought of it. You see it's a different job over there now. Whereas the men [porters etc] do actually look after the patients here the men will be doing the cleaning over in Clonmel. In Clonmel it's the carers who will be looking after the patients but we are looking after patients here for years and we were never called carers (Cashel Support-service pre-merger).*

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<sup>53</sup> Document presented to me by Integration Manager December 2003



*I think their patient case-load is a lot harder, medical patients are sicker and need a lot more care than surgical patients do (Cashel Patient-carer (4) pre-merger).*

*They start their week on a Monday but we start on a Sunday but we are hoping to start our week on a Monday. There will be talks about that shortly. In some places over there they do not start until 8.30am, we start here at 7.45am, they will have to adjust to that (Clonmel Support-services (3) pre-merger).*

Again as in the financial services firm it was many of the smaller aspects of the work environment that created concern in both Cashel and Clonmel.

*I think all the things I said [earlier]. All the traveling, getting up earlier, the uniform issue, car-parking, things like that. You literally can park your car right outside the door here and walk in. Things like the canteen as well and having different management is a huge thing (Cashel Patient-carer (3) pre-merger).*

*We will have to sort out an off-duty rota and a uniform policy (Clonmel Patient-carer (3) pre-merger).*

At another level however the similarity of the core job of a hospital professional was expressed.

*I imagine we are similar enough really. (Cashel Patient-carer (3) pre-merger).*

*I think the changes here will just be more people around. I can't see a whole lot of changes from an operational point of view..... I know there may be issues around theatre and theatre time but I think that is a problem in every hospital (Clonmel Patient-carer (2) pre-merger).*

There was also some recognition by the Clonmel staff that the transfer of services would be problematic for Cashel and a great deal of sympathy was expressed that their terms might change as a result of transferring.

*They are more vulnerable than us. It is a big change for them because it is a different working environment (Clonmel Patient-carer (1) pre-merger).*

*They [Cashel] are leaving their own working environment to come work someplace totally different. The little perks that they have up there like*

*coffee mornings, scones on a payday etc., we used to have that but it has slowly disappeared from here. They would have a lot to give up. I think that is a lot of their fears as well (Clonmel Patient-carer (3) pre-merger).*

Overall however the major work change perceived pre-amalgamation was the need to be more flexible post-merger.

*Management may have to get a bit more flexible. They have different working times in Cashel so there may be different shift times. It is all up for discussion at the moment. I think the management structure is changing anyway so we are going to have a medical and a surgical director. We are not sure what is going to happen (Clonmel Patient-carer (2) pre-merger).*

These comments suggest the unfamiliar nature of the new work structures hence the Clonmel group's recognition of a need to be more 'flexible' and Cashel staff's fear of 'more control' are expressed as unknown quantities. These work boundaries were the primary basis for potential disputes pre-merger as union and staff tried to negotiate agreements.

Post-merger, differences in the job description came increasingly into focus, primarily due to the busyness of the hospital post-merger and the reduced staffing levels. There were clear examples of the struggle of staff with the unfamiliar.

*One day I had to go over for an emergency and even just knowing the codes to get in to the theatre in an emergency and then when I went in to the theatre where the c-section should have been it wasn't in there it was in a different theatre. Because we were used to having one theatre as opposed to three and then everybody dressed the same so you didn't know the difference between the doctors and porters (Clonmel Patient-care (4) post-merger).*

*We still basically do the same thing. Now the only worry is if surgical run out you will be getting medical patients. So sometimes you will have patients that you never would have had in Cashel (Cashel Care-assistant (2) post-merger).*



There was also the clear view that services were improving and that while the transition was difficult it had been achieved. Issues such as holiday leave and the starting times and hours worked were still being debated.

*Organising rosters and duties and everything for two sets of people for both to amalgamate and getting skill mix together is a huge thing because at the end of the day it is an area that needs to be staffed appropriately, properly and with high-skilled people so it wasn't about what really people wanted it was about the service needed. And it was a huge transformation. But it is there and it is working very well now (Clonmel Patient-carer (3) post-merger).*

*We work by best practice and by policies and guidelines and a lot of those were drawn up while we were in Cashel so we brought them with us. ... there is nobody standing over us telling us "this is the way we do it in Clonmel", not once has that been said to me since I came no matter what [the issue] was. Obviously there were differences with household type issues and ordering and pharmacy and all those kind of things and yeah they have a different way of doing it but they are good ways and they are very streamlined and they work very well. ... No it's international best practice all around (Cashel Patient-carer (2) post-merger).*

The job description boundary discussed above has strong similarities to the financial studies case and many of the same issues were relevant in both cases. The voice of the staff clearly points to uncertainty and tensions around the unfamiliar structures, such as starting hours, on-call duty or levels of flexibility, that would be created in the new hospital.

#### 8.2.1.2 Service set

The service set is the range of services that are offered in each of the merging units. In the financial services study this was initially called product set to reflect the tangible nature of their outputs. In a hospital it is more accurate to refer to the outputs as services.

There was substantial difference between the two hospitals in terms of service delivery. Broadly, the Cashel hospital was a surgical facility combining planned surgical operations with an accident and emergency service. In contrast Clonmel provided medical facilities dealing with longer-term medical issues. It had limited surgical capacity and a minor accident and emergency unit. These differences in service provision were well understood by all staff on both sites and had for a long time demarcated the provision of services in South Tipperary.

*Well they are medical and we are surgical (Cashel Patient-carer (4) pre-merger).*

*Services are different. Surgery is different to medicine (Clonmel Patient-Carer (5) pre-merger).*

These differences translated into a set of concerns about the level of skills and awareness each had of the other's services and a fear that they would have to engage with this unfamiliar service.

*I suppose obviously in Clonmel; there is a lot more in it. We centre around surgery. They have coronary care and cardiac department etc. We just concentrate on the one facet of care. There is more in Clonmel even though it's a strictly medical hospital there are more departments in it, it's bigger as well (Cashel Patient-carer (3) pre-merger).*

*We are very medically orientated and work at a certain pace all the time whereas in surgery it is slightly different even though they are busy (Clonmel Patient-carer (2) pre-merger).*

The driving force for the amalgamation and the logic for the change was the improvement in services and the reduced clinical risk that would exist through the location of both services on the one site. Not all the staff in Cashel agreed with this however and some support for the separation of services existed. Particularly important was that because Cashel was a stand-alone surgical hospital there was no pressure on the hospital from medical patients. Medical



patients tend to be sicker and in need of a longer-term stay and less predictable in terms of care needs. Thus they tied up beds. By protecting surgical beds from the medical patients, surgeons faced an easier planning process and could ensure waiting lists were kept to a minimum. Furthermore, Cashel staff also believed that there may be issues that would emerge because the difficulty in bring the two sites together had been underestimated.

*Over there, there is going to be less beds. So where are these people going to go? At the moment in Cashel there is not much of a waiting list. If you want surgery, you will have it done in 4-6 weeks but I know when we go to Clonmel there will probably be big waiting lists (Cashel Patient-carer (7) pre-merger).*

*I think that South Tipperary General has no idea how many RTA's<sup>54</sup> come in here on a regular basis and when there's major crisis in the A&E. They have a medical emergence facility; they have never experienced major traumas with 5-6 serious injuries, their families and all the other people that go with it such as the Guards. To deal with that many people in an emergency room that is actually smaller than the one that is here. .... I think it will be very difficult for the A&E staff (Cashel Patient-carer (7) pre-merger).*

The differences in the services set were compounded by the range of services that would remain in the Cashel hospital once the new development had taken place. These services would be completely different to those that traditionally exist on the Cashel campus and would include geriatric and disability care role.

*In Cashel there will be a huge sense of bereavement which is the word we often use for it because a lot of the staff that are staying have been here a long time, some for 20-30 years who have worked in surgery all their careers, their colleagues are moving and then there is a huge change of service for our site to a completely communit- based elderly care. A different focus of care altogether to what we have been used to (Cashel Care-management pre-merger).*

*People who joined the surgical area to be surgical staff, what's going to be here is the likes of the geriatrics unit and that is a totally different career. It's not a career of choice maybe for a lot of people (Cashel Administrator pre-merger).*

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<sup>54</sup> Road Traffic Accidents

The perception of the transfer of service in Clonmel was that a bigger and better hospital was being created (in terms of its service delivery).

*The service is going to improve from the patient/client point of view. The service has got to improve dramatically. Having both medical and surgical services under one roof has got to be of a huge benefit (Clonmel Patient-Carer (4) pre-merger).*

*Another positive thing is that the services in Cashel have not been able to develop properly before because they are waiting for the transfer of services (Clonmel Clinical-care (3) pre-merger).*

Post-merger the services set difference was more evident to staff as they were faced with a busier hospital. Staff generally favoured the new services set and the additional benefits or challenges they presented. Issues of learning and personal development were strong themes in the descriptions presented by staff. The hospital management invested heavily to ensure training and support facilities were available to staff so that work related training could be delivered as needed.

*Of course the staff here were more or less medical orientated but they have adapted to us and we have adapted to them. It's a matter of mutual cooperation which I find in abundance here (Cashel Clinical-care post-merger).*

*I feel everybody wanted to try hard to make it very good and that might have been harder to achieve then we thought. I'm not talking about the staff, again I am talking about the services. All the staff that were coming over were coming into a completely different area. They were very unfamiliar with medical, obs and gyny, things that they knew nothing about. You would have to feel sympathy for them too (Clonmel Patient-carer (5) post-merger).*

In addition a positive attitude to the new fully integrated services had developed among staff. The logic of improving services was seen and clearly visible. This positive attitude was also a strong theme in the staff questionnaire. Over 77% of the respondents (n=364) reported some level of agreement with the statement



*“The Hospital provides better services now than when the services were on separate sites”* and 74% reporting some level of agreement with the statement *“Our service continues to improve all of the time.”* Some inter-group differences did exist in these levels of agreements with Cashel staff reporting a lower mean score (3.91 and 4.29 versus 6.19 and 5.40 respectively) and higher standard deviation (1.93 and 2.03 versus 1.24 and 1.57 respectively). The stronger belief that services had improved among Clonmel staff was reflected in far greater frequency of positive comments among them than among Cashel staff.

*There is a huge difference in services because you have got everything in the one place now. When we worked in Cashel in the A&E if you had a medical you might have to send them here and then they come back. Now you don't have to do that (Cashel Care-assistant (2) post-merger).*

*It is good really because everything is under the one roof. A&E is here and surgical. You don't have to transfer over to Cashel and back. It is good. We are all combined now. I know it was a big move, everyone was just dreading the big move and would it ever happen, but it has happened now and I think it is good to have everything here (Clonmel Administrator (3) post-merger).*

The services set boundary shows strong identifiable differences between the two services and the concerns of the staff, particularly in Cashel, about dealing with the unfamiliar demands of the other hospital's patients. There were several potential conflicts that might have emerged especially in relation to staff being unwilling to engage any additional services, such as the call from Cashel that their staff would remain in surgical areas. However the coming together of the two hospitals alleviated many of the fears and the unfamiliarity. The teams worked together in an understanding way and learned about the other's activities in a constructive environment. It is also possible that the demands of the work coupled with the shortages in staffing drove the teams together in the interest of patient care.

### 8.2.1.3 Location

In the financial services study, location boundaries related to the physical location and layout of the branches. Again a similar issue arose in the Hospital study with the staff strongly identifying with the actual physical characteristics of the hospital. The state of repair of the two separate hospitals was also a distinguishing factor. The ‘old’ Cashel hospital was suffering from a ‘*lack of investment*’ and increasingly falling into disrepair. Indeed in some ways the motivation to move was stimulated by a fear that services could not continue in the old hospital. It nevertheless was ‘*home*’ for many of the staff and evoked strong emotions when departing. *I think it’s just the dread of leaving here and moving. That we have to move and amalgamate with them. (Cashel Patient-carer (7) pre-merger)*. In contrast the Clonmel hospital had many newly built sections and provided state of the art in hospital facilities. This gave a strong incentive for staff transferring as they were improving their working conditions.

*Nurses and staff will hopefully have a better environment to work in, like the walls won’t be cracked and falling, the windows will work, there will be piped oxygen and suction, and systems in place to support what’s going on. At the moment you can’t get curtains changed here as no one has been identified as the person who is going to change curtains. There are systems and processes in place over there that will support the work that we do (Cashel Patient-carer pre-merger).*

*The walls are peeling and there has been no money spent on it in years purely because they are moving. They are moving into a better building and better facilities. It is going to be a big benefit (Clonmel Patient-carer (2) pre-merger).*

Notwithstanding the positive feeling about the new move Cashel staff felt some sense of unease that they were moving to Clonmel and into ‘*their space*.’

*And the fact of moving in on someone else’s territory, I think that had the services merged on a completely new building and that both sides are going in as equals. There is a little bit of a feeling of Clonmel having the upper hand because Clonmel aren’t moving and we are going in not*



*necessarily as the underdogs, but we are going in as the new people and we have heard reports that there isn't actually enough room for all the people going over there that we will be squashing in on people (Cashel Administrator pre-merger)*

*Even in the departments, I am going over to the day ward and they have already taken ownership of the space, they have been using it for the last six months so you do feel that it's a "them and us" situation. We are going to have to fight to keep our ground. However, it shouldn't be that way, we know that (Cashel Patient-carer pre-merger).*

*There will be a certain amount of fear, that we might feel that Cashel will be in against us and that maybe they will be taking our space (Clonmel Patient-carer (1) pre-merger).*

Clonmel staff sympathized with the Cashel group and understood the difficulties that moving to Clonmel might bring.

*I do think that moving here will have a negative impact coming to smaller beds [numbers]. It was planned years ago when the service over there was much less. The resources here for them are probably not enough than they actually need so ..... I can definitely see the advantages of staying in Cashel but from a patient point of view it is not safe (Clonmel Patient-carer (2) pre-merger).*

*I know everybody is worried about Cashel and how they are going to fit in but I am sure people here feel threatened and vulnerable as well. It is going to be different for everybody. There will be new faces around and it is not going to be easy. You have to make the effort to make them feel welcome but I think we need to be as well. We can feel vulnerable as well. Where is my desk going to be etc? It is just going to be a little bit awkward (Clonmel Administrator (2) pre-merger).*

Again a clear feeling among the Clonmel staff was the improvement in the building that had been achieved in planning for the amalgamation.

*I think it is a good thing for the hospital, all the new equipment. Even just to walk along the corridor now and see all the machines with plastic bags over them. By the time they come they will have new machines and new equipment (Clonmel Administrator (1) pre-merger).*

Post-merger the Cashel staff had mixed feelings about the new premises and the facilities on offer. Conflict in the financial services study was expressed in terms

of new location not being up to the standards of the other facility. Similarly, hospital staff considered location as being ‘*laid out incorrectly*’ or because they were deficient in some respects, such as space or facilities. In addition the Cashel group often drew comparisons between the older part of the Clonmel building and the newer part suggesting that part of the building wasn’t at all up to standard.

*You do a lot of walking here in this place. It’s badly designed I think. From a walking point of view it’s too spread out. You have got stores at one end and stores at the other end. You could be working in the middle and get back to the room realising that you have forgotten a dressing and you have to walk all the way back. There is nothing on hand, you have got to walk. Plus, not like in Cashel where there was a couple of main wards that you could walk through, the wards, here, you have to keep going out to get to the next one. You felt that for the first couple of weeks. I was wrecked compared to in Cashel because of the walking (Cashel Care-assistant (2) post-merger).*

*The older part of the hospital is very badly in need of refurbishment (Cashel Patient-carer (5) post-merger).*

*The hospital isn’t big enough for the volume of numbers passing through..... the corridors are so narrow in the old building, you are hopping beds off the wall you know, you can’t pass people on the corridor with patients in beds. Like in Cashel the corridors could have passed two beds no problem (Cashel Care-assistant (3) post-merger).*

Clonmel staff was also cognisant of the space issue and that the hospital was cramped but tended to be more accepting of the problem and possibly more anticipatory of solutions. It is possible that their greater familiarity with the building and its history of development made them view the problem as part of the longer-term ongoing changes within the hospital’s physical environment.

*There was a lot going on, no space over in A&E, but it is not just A&E it is surgical as well. As in A&E is where most of it happens but there is no space over there: the staff are on top of each other and that impacts on everybody because there is bad morale, staff are not happy (Clonmel Administrator (3) post-merger).*



*I suppose the conflict was that although they came to a new premises it wasn't big enough with regard to storage and it caused a lot of problems in ICU in particular. They had massive problems with storage and equipment. ....The same on the surgical ward (Clonmel Patient-carer (2) post-merger).*

Once again the Clonmel group also had a positive outlook on the better services and facilities that the merger had brought to the hospital.

*Where Cashel were the building was older and didn't have great facilities for the patients whereas now on the surgical ward they have a brand new modern building with loads of facilities, en-suite toilets, showers, so it is a lot more comfortable than what it was in Cashel (Clonmel Clinical-care post-merger).*

*Betty<sup>55</sup>, the girl with me, was like a duck out of water when she arrived. She didn't know where to sit, it is hard but now she will tell you she wouldn't go back to Cashel. She is happy here (Clonmel Administrator (3) post-merger).*

The suitability of the location was also raised by staff and the discussion on whether the hospital should have been on a new site and build from scratch as a totally new hospital was also common. However, when this was linked to the location, post-merger, it was proffered as a solution to the problems that existed insofar as it might have prevented the space and other problems emerging.

*Get a big green field somewhere with a state-of-the-art hospital would probably have been the answer and would probably have cost less in the long run (Cashel Care-assistant (3) post-merger).*

*I think the decision to utilise this building was a bad idea. We have been stuck with it and we have problems now even trying to man it because some parts are so old. It is hard to reconfigure it to today's standards. That is a big negative issue here that we are stuck to the confines of this front visage. The development now is really ad hoc. I do think it would have been better if it was a Greenfield site (Clonmel Patient-carer (2) pre-merger).*

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<sup>55</sup> Betty is a pseudonym

The tension created by the move to a new building was clearly evident in the Cashel group but the uncertainty that his transfer created was mitigated to a large degree by the state of the old Cashel building and the modernness of the new building. Nonetheless the potential for conflict was again clear as the building in Clonmel failed to suit all of the staff's needs. A similar discourse of the 'building isn't suitable' was evident in both the hospital study and the financial services study.

#### 8.2.1.4 Colleagues

Colleagues refer to the make-up of the work team and the make-up of the relationships within and across work teams. Again consistent with the financial services study the primary perceived change to the colleagues was the increasing size of the work-unit. However unlike the financial services study the work group changed from time to time as a result of work-practices (i.e. shifts and on-call duty). The result was that different people constituted the work teams from time to time. Notwithstanding these practices the increasing size of the hospital was of concern to both hospitals and often resulted in fears over 'not knowing people.'

*Here we know everyone, when we go there you may not know the others on the other wards. I feel that we are going over and they feel that we are just nurses from Cashel and they don't have very much respect for us that we are just another number (Cashel Patient-carer (4) pre-merger).*

*In a small place each person is a big fish in a small pond and suddenly they are going to be small fish in a bigger pond (Cashel Care-management pre-merger).*

The pre-merger Clonmel interviews painted a very similar picture with concerns over the increasing size of the hospital and the impacts that might have on the



team interactions. The perspective of the team changes however often tended to focus more on how Cashel staff would ‘slot-in’<sup>56</sup> rather than the impact it would have on the Clonmel team. Part of this might have been the assumption that the two hospitals would remain largely separated and be largely self-contained. In addition Clonmel, in line with larger hospitals generally, had a larger turnover of staff so that incoming and outgoing staff were just part of the daily fabric of operations.

*From a staff perspective, there are so many staff here that we do not know each other any more. It is one of the big drawbacks that when Cashel come here there will be far more staff here. You will know less and less staff. There was a time when someone new came you would know straight away that they were new. That is gone already though and it is not just because Cashel will be coming over. I met a man last week and he has been working in the lab for two years and I had never seen him before (Clonmel Support-services (3) pre-merger).*

Once again the Clonmel staff appeared to sense that the transfer would have greater impacts on the Cashel group than on the Clonmel group and that the transition would be more problematic for them given the changes to their team structure (staff were being left behind so their team would be broken-up).

*It is going to be harder for the Cashel staff because they may feel it is “them” and “us” but we will not allow that to happen. That is everyone’s aim. They will be integrating with our own staff. They will not be working separately. We will make sure that once they come here they will be shown everything (Clonmel Support-services (3) pre-merger).*

There were some cases where the potential impact on the Clonmel team and the changes to its constitution was seen as a potential problem.

*It is going to be different for everybody. There will be new faces around and it is not going to be easy. You have to make the effort to make them feel welcome but I think we need to be as well (Clonmel Administrator (2) pre-merger).*

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<sup>56</sup> Clonmel Administrator (1) pre-merger

*I hope our staff and emergency room stay the same. Medical wards will stay the same but I think overall everything else will change. Of course there will be different personalities and different people coming into the department, especially the amalgamating departments. ... I suppose people fear for their work in the department (Clonmel Patient-carer (3) pre-merger).*

Many of the fears about the increasing size of the hospital did in fact materialise.

The overriding themes post-merger was the scale of the hospital, how busy it had become and how so many more people were in the hospital.

*It's bigger so you have the bigger hospital ethos. It's kind of like moving from a little old country cottage to an apartment in the city. It's that kind of a thing. No I don't think that it can be compared. It's not worse, it's not better, it's just different. And I'm sure the people in Clonmel feel the same way since we have invaded their space. Their space has changed you know (Cashel Patient-carer (2) post-merger).*

*Well I suppose the biggest thing you notice is that you don't know everybody. Whereas you did before. There are new doctors that you couldn't keep up with. There are new nurses and care attendants that kind of thing (Clonmel Patient-carer (4) post-merger)*

There were clear examples of boundary problems that did emerge within various teams. Personality clashes were reported as were issues of unfamiliarity because of the sheer increase in numbers of people. The individual team member did not quite know how to deal with the consequences of all these new people. Over time this problem dissipated as familiarity with people and their actions developed.

*For example in the [department], as in the secretary in the [department] and the girl that came over didn't get on at all. Like a personality clash, made it hard on everybody over there. I don't know if the girl here thinks that the other girl was invading her space or what but that had to be sorted out and now it seems to be okay. That's just a small example. I do think it is getting better and easier for the people here and the people who came over (Clonmel Administrator (3) post-merger).*

*Another thing is the noise level, I know you are probably thinking that this person can't cope with a bit of noise!! But going from working in an environment where there is five people to suddenly there are 11 and you can imagine the noise, increased noise now. The phones, we had two lines now we have six, they are hopping all the time, it can be quite difficult at times to concentrate on what you are doing yourself with all*



*the noise around you and people shouting, who is doing this or who is doing that. It is quite difficult (Clonmel Administrator (2) post-merger).*

There were also some positive comments on how the difficulties resolved themselves. Issues were dealt with as they emerged and when clashes arose they were faced head-on and resolved. Over time the groups appeared to resolve the issues.

*We know more about them [Cashel Staff] now. Some of them you would have known vaguely. We know more about them. They are very nice girls. I find the girls very easy to work with. It's like they were here all their lives. They settled in quite well and they are all quite happy (Clonmel Support-services (2) post-merger).*

*As regards the area that I work in changed it seems to have evolved quite smoothly, the new staff that came on board gelled in with us, we didn't have any problems, they are a nice bunch of girls. We are getting on well and we are having no problems (Clonmel Patient-carer (5) post-merger).*

The changes to colleagues caused clear difficulties for the staff. A very evident sense of concern over the increases in team size existed in both Cashel and Clonmel pre-merger. These concerns translated in practice to an uncertain and unfamiliar environment post-merger. They did, in some instance, translate into conflicts. Indeed the post-merger executive transfer meetings identified a number of small problems that related to team behaviour, such as interactions between units and personality clashes. They were accepted as emerging from the frustration of staff rather than workflow issues. As conflicts emerged, established resolution mechanisms, such as line management intervention or referral to the operational transfer or partnership groups, ensured that the problem was addressed. The results evidently show that six months post-merger the conflicts had dissipated and were, on the whole resolved.

#### 8.2.1.5 Owners

Owners as a potential for difference was not relevant in the hospital study. The ownership structure of the hospital was not changing and the governance and management structure remained the same pre and post-merger. This is one primary difference between a public sector study and a private sector study. In the former amalgamations can occur without ownership changes.

#### 8.2.1.6 IT Systems

In the financial services study the IT systems were an interface for staff to access their work and to perform their duties. This in turn created a strong association between the IT interface and the daily activities of the staff and provided a sense of familiarity of routines for staff. Hospitals are faced towards patient care rather than transaction processing and are accordingly not as dependent on IT as a financial services firm. Furthermore the IT systems within the HSE acted to homogenized IT where direct interfaces did occurred, as in for instance the administration areas. IT was not therefore a key element in the differences between the two hospitals. Nonetheless, the technical environment of the hospital, including communications, did have technical interfaces and in a few instances these were identified as potentially conflict-creating.

Pre-merger, the impacts of technology on the merger were not at all evident in the minds of staff. Only two references to technology was made in the pre-merger interviews and one of those related to '*keeping up with technology*<sup>57</sup>'. The

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<sup>57</sup> Clonmel Patient-carer (1) pre-merger



Cashel reference was a hope that the technical environment would improve once the transfer to Clonmel occurred.

The potential for conflicts to occur was more evident post-merger but did not appear to be a substantial issue in the minds of staff. References were made to improvements in the technology environment of the hospital.

*Everything now driven through email I have no problem with it but sometimes it's a bit impersonal. You could nearly meet someone in the corridor and they won't tell you but you go back and you find an email from them you know that kind of way (Cashel Patient-carer (2) post-merger).*

The IT boundary was not significant for any of the staff in the two hospitals.

There were differences in technology usage and practice between the hospitals but these differences were not of sufficient importance to develop any problems post-merger.

#### 8.2.1.7 Leadership

A strong physical manifestation of the branch and its boundary with others within the financial services study was the branch manager. The branch manager represented a strong symbol of leadership and the person behind which the branch could unite. In the hospital study, the Hospital Manager was responsible for both sites. She was accordingly well known in both hospitals. Furthermore, the administrative management team (including the Integration Manager) worked across both hospital sites. However, while all of the staff knew the Hospital Manager, for most individuals, their more immediate leader would have been the unit or services manager in their area (i.e. Director of Nursing) to whom they would have looked for work-related matters and leadership. The leadership was

further complicated because staff had both line reporting based on professional issues, for example nursing, and a clinical reporting line based on the clinical practice (i.e. to a doctor or ward).

The leadership boundary offered potential for staff problems to emerge post-merger. The letters of comfort, giving staff in Cashel the decision whether to move or not, were in the most part held by the staff with long service histories and with seniority (formal and informal). If the senior staff were not going to transfer over, there would be a resulting loss of leadership (and skills and knowledge). As a result transferring staff were likely to have new team leaders and managers once they transferred to Clonmel. In this respect there is a similarity with the financial study, in that one group was set to lose its management team.

There was a strong acceptance in Cashel that their management structures were more flexible and less hierarchical than the larger Clonmel hospital and that this was part of the 'family' approach to operations that symbolised Cashel.

*You work so closely with everyone here and there is not so many lines drawn or levels. Levels of employment don't really come into it here. I think in Clonmel that people are made aware of who is superior; I think that attitude is there. And it's not disrespectful the manner in the way they work it's just the atmosphere (Cashel Administrator pre-merger).*

*Here we have very approachable management. We all kind of pull together. I imagine from what I have heard of management over there that things are different and you know we are going to see huge changes (Cashel Patient-carer (3) pre-merger).*

*We have staff who for different reasons can't work certain days due to family commitments and everyone knows it so there is no issue with it. But when you amalgamate them into a huge place where maybe their problem isn't known or they might not want to make their problem known, and yet the minute you ask them there's going to be a blank wall.*



*Where do you go? But it's a small place and you can do that. I have worked in huge places way bigger than here and you have to be totally across the board whereas in a small place you can be a little bit more personalised and because everybody in the place possibly knows why x can't do whatever but in a bigger place it might be seen that x is getting preferential treatment (Cashel Care-management pre-merger).*

A fear for Cashel staff, leading up to the merger, was the potential loss of their management structures. There were two dimensions to this fear. Firstly, senior staff may not transfer and secondly, Clonmel may not recognise the informal position of long-service staff given that they would all be subject to the more formal Clonmel authority structure. Typically, there was a fear that long-service would not be recognised and that the history built up in an area would be lost.

*The other thing in this hospital is that people have been here for up to 30 years and that is no exaggeration, they might not have the rank but because they have been here for so long they have the seniority which automatically gives them that position, and people look up to them. .... Even if someone has been here for 30 years and they go to Clonmel and they try and tell someone, even if that person has only been there for two years it's not going to have that same effect because they have been in Clonmel all the time (Cashel Care-assistant pre-merger).*

*Actually the main problem we have here is that no senior management from here are going over to Clonmel so we will have no senior management to represent us: we have to amalgamate in with their senior management and do what they want. We have no voice really at senior management level..... they should have been somebody who is transferring that we have somebody from here on our side in the senior management (Cashel Patient-carer (7) pre-merger).*

There was also an acceptance that the management in Clonmel was effective and was motivated to complete the amalgamation in a positive and professional manner. It also recognised that there would be a more formalised regime but that this was not necessarily a negative outcome.

*...it's just going to come to the fact that management, to do their job properly, will just have to put their foot down. They need to do that from the beginning. As far as I know the management there is very good and they seem willing to compromise to start off with and that's what they*

*must do. I know we had a meeting last week with the [manager] and we got on fine, they understood where we were coming from and they are asking us to come up with what rosters we wanted and said that if there's a problem we will sort it out and that's the way to go forward. They didn't come in and say that 'this is what we want' because that is going down the wrong road (Cashel Care-assistant pre-merger).*

*There will be more layers of management. ....access to the people who can make decisions will be more difficult. That can actually be a positive thing as well because you can identify issues and pass them onto someone more senior (Cashel Patient-carer pre-merger).*

In contrast Clonmel were not focused on the leadership issue. They acknowledge that their management structures would remain largely intact. Their concern, once again, was more with the perceived threat to Cashel staff of having to deal with a new management set-up.

*At the moment they may be wondering what it is like. They have a different director of nursing and they will probably be worried they might not be able to get their night off work or whom do I go through if the CNM goes through them (Clonmel Patient-carer (1) pre-merger).*

*I think the perception in Cashel is that they are going to come here and it is going to be harder to deal with the [line manager]. I find personally that both sides are quite amenable as well. I find in both sides there are issues but both of them are quite approachable when it comes down to it (Clonmel Patient-carer (2) pre-merger).*

Post-merger, the staff appeared to have a positive outlook toward the leadership position. The questionnaire data shows that 53% of staff agreed with the statement “*When problems or issues arise they are dealt with effectively.*” This compared to only 30% who disagreed. Examining the means of Cashel and Clonmel staff shows some minor differences (mean of 3.58 as against 4.38 overall) but the former has a higher standard deviation (2.01 as against 1.87) suggesting a more diverse opinion set. Similarly, the staff reported positive sentiment toward the level of communication and that their views and opinions were taken into account by management (mean 4.54). Most importantly,



however, 65% of staff agreed that “*my manager is responding to the issues of most importance to me*” compared to 25% who disagreed. Examining the differences between the Cashel group and others suggest a positive attitude from the Cashel group. Their mean was 4.27 compared to the overall average of 4.81.

Clonmel staff did not appear to consider that the leadership was a substantial issue in the merger. Some comments about *lines of accountability being pretty much the same* (Clonmel Patient-carer (2) post-merger) were coupled with *feeling I have an input* (Clonmel Support-services (2) post-merger). Some comparatives were made between Cashel and Clonmel drawing conclusions that the Cashel group *did not have the same supervision as over in [Clonmel]* (Clonmel Support-services (2) post-merger) and that this would mean they may be perceived less favorably.

The Cashel group seemed to feel that the new structures had worked well for them and they were very positive about the new management structures.

*It's a lot better and everything is dealt with. If I have an issue I know I am going to talk to someone who will handle the issue (Cashel Care-assistant (2) post-merger).*

*Our [unit leader] became [unit manager] and she had already moved over here so we had good communication channels, we knew what was going on and because she had come from the unit she knew exactly what was needed (Cashel Patient-care manager (2) post-merger).*

The positive comments from the Cashel staff were occasionally contrasted with negative sentiments. These sentiments reflected a sense of isolation from the leaders and that the individual staff was not adequately engaged with the manager in the same familiar way of Cashel.

*You have to make an appointment to go down if you wanted to meet management ..... you just can't walk down and go into the office like you could in Cashel. Plus the fact I suppose that when we came here we felt isolated because our own, the management was totally different and once you got here it was you are here and that's it. Our own managers here on this floor were so busy organising the whole lot that nobody came to see what our needs were; do you know what I mean? Nobody seemed to be interested (Cashel Care-assistant (1) post-merger).*

*If you have any problems you can always go up into [management office]. But I mean our [manager] was a female in Cashel and she worked with the [Staff] as well, they all worked from the same room and they did come around to the wards quite a bit but [new manager], I haven't seen coming around that much but maybe because it's a bigger hospital maybe he hasn't the time or whatever (Cashel Patient-carer (6) post-merger).*

The analysis of the leadership boundary in the hospital highlights the same trend as the previous boundaries. Strong and potentially problematic divides existed between Cashel and Clonmel and a strong sense of uncertainty existed about the new leader. Some residue of perceived differences existed post-merger but the boundary differences had not become salient or created any lasting difference that separated the two units.

### **8.2.2 Behavioural Boundaries**

The definition of behavioural boundaries adopted in the financial services study was acts or actions that are acceptable or expected within a given context. Four behavioural categories were identified.

1. Personal Investment
2. Work Processes
3. Team Behaviour
4. Customer Service



### 8.2.2.1 Personal Investment

The financial study developed the concept of a personal investment boundary that relates to the commitment a member of staff is willing to invest in their work. This was considered in terms of references to the amount of time they are willing to spend over and above their standard day, their commitment to making the branch work effectively, the extra volume of work they were willing to take on and the belief that an input/reward process exists that specifies the level of investment that is appropriate for a given position/task. A primary difference between the financial services study and the hospital study is the difference between private industry and public service. The public service has more tightly defined roles, responsibilities and career structures. Public service is also more time-flexible and family friendly than most non-public sector industries. An important characteristic of the public sector is its strong unionisation and collective action that serves to homogenise rules for promotion, overtime opportunities and management-staff interaction. In this respect the ability of staff to 'contribute over and above their standard day' is different from the financial services study. Overtime, for instance, is paid and structured according to defined agreed guidelines. Performing overtime duties is actually seen as generating additional income for the individual and is accordingly a benefit rather than a commitment. Indeed, particularly within the build-up to merger day substantial overtime was being worked across the hospital and calls for additional resources to be put in place often came through at the executive transfer meetings. Given that a common union represented staff in each of the two hospitals, any overtime or activities outside of the norm were treated in

exactly the same way in both sites. Unsurprisingly, neither group saw the overtime issue as a critical indicator of commitment.

A second factor in determining the level of personal investment is the size of the hospital and how it relates to the distribution of tasks and responsibilities. In many instances the responsibility for any activity rested in a group of people rather than a single individual. So, for instance, if a need to do a particular job was identified there was often a pool of people from which to draw and the manager of the area would be assigned responsibility for allocating the task. In this respect it was less clear who was or was not investing heavily in the job.

The concept of personal investment however did emerge in the hospital study. Similar to the notion of 'no slackers' that was described in the financial study, staff members were strongly committed to delivering on patient care and ensuring that the operating procedures in the hospital delivered the best care possible. There was a unified assumption in both hospitals that everyone delivered the best care possible and that this assumption should not be questioned. That is not to say that procedures could not be improved, quite the contrary, but that the motivation of staff was evident and established. Where improvements were needed these were operating and pathway problems.

*I just think that everybody here gives 100% and they are appreciated for it and the management are appreciative and they know how much work you do (Cashel Patient-carer (7) pre-merger).*

*Personal commitment everyone gives 100% the patient is number 1 (Clonmel Patient-carer (3) post-merger).*

*Willingness on the part of the staff to make it work [is why it has worked well]. Despite the reluctance initially and the movement of the service*



*from Cashel I think people wanted it to work to provide a better service for people in the community (Clonmel clinical-care post-merger).*

Another dimension was the visibility of staff commitment. This was somewhat different to the financial study. The departments within the hospital were largely 'loosely coupled' with workflow and personal interdependence at reasonably low levels. Hence, the day ward seldom interacted with the emergency department or surgical seldom interacted with pediatrics and so on. It was therefore harder for staff to assess personal levels of commitment and often assumed theirs was the benchmark for the entire hospital.

In many cases a strong feeling existed that staff contributes above and beyond the call of duty.

*I suppose there is more commitment expected because we are so short staffed (Cashel Patient-carer (2) post-merger).*

*..so much busier sometimes you feel if there is anything thought of you for doing all this extra work. That is sometimes a bit disheartening (Clonmel Administrator (3) post-merger).*

*..wards have their own little idea that they are the busiest in the place and no one else is busy (Clonmel Patient-carer (2) pre-merger).*

There were examples however of where perceived levels of commitment between the groups were viewed as different.

*I am just speaking personally, I would give a big commitment to my work as would the people that worked here before. I'm not trying to be boastful or bragging but we would have been we are very committed to our work. ... I just don't know if the others are as committed (Clonmel Administrator (2) post-merger).*

*I think its very important for people to pull their own weight and I know this is not going to be repeated back but there is a few staff that don't pull their own weight in their areas ....you know it leads to low morale as well (anon).*

Finally, the level of personal investment was sometimes related to the deal that was agreed with the Cashel staff. Payments were made to all transferring staff from Cashel but staff in Clonmel received nothing. They perceived however that their commitment and disturbance should have been recognised.

*Its just go go go all the time. It is hard because everyone was involved in Cashel and sorting them out and helping them out as regards how they were going to feel whereas we were just told to put up with it, you know that kind of way. And take on all this extra work, there was no deal for us (Clonmel Administrator (3) post-merger).*

Differences in the perceived level of commitment appeared to stem from the individual rather than the hospital, with individual traits, management and locum cover being blamed for commitment variations. This boundary does not appear to create any significant conflict within the case, for the reasons discussed above. Notwithstanding the apparent lack of conflict the confusion that is caused over the expected commitment level is evident.

#### 8.2.2.2 Work Processes

Work processes relate to the ways in which the tasks and responsibilities of the groups are discharged. Work processes differ from job description in that the latter bounds what must be done while the former bounds how it must be done. Patient pathways and workflow issues were probably one of the most spoken about issues at the transfer meetings, next only to the physical and facilities development. These discussions typically centred on how to best achieve a particular task or activity. For instance, several of the executive transfer meetings leading up to the transfer spent significant time discussing the 'book.' The book was a diary held by the surgical secretariat and which was used to book patients into each surgeon's schedule. The surgeons were committed to this book and



insisted that no other system could be applied, even though their system was not compatible with Clonmel practices and substantial duplication and process problems would emerge if it were retained. Finally, the 'book' got accepted into the admissions systems and the work process of secretaries managing the appointments through the book continued.

The potential for work practice problems was identified from early in the amalgamation process. The partnership structure facilitated groups to share practice and design new agreed structures. This was always a key component of the amalgamation plan. By getting staff working together and moving to best practice, work processes would be homogenised. The partnership structure worked extremely well and all of the major patient pathways (work processes) were agreed pre-merger. Notwithstanding this success there was clear evidence that differences were substantial and that they provided the potential for conflict to occur.

The first area of difference related to the flexibility in the tasks completed by staff. In particular, given the smaller size of Cashel there was much more variation in the job and a staff member could be asked to work in a number of different areas. The formalisation of process and the larger size in Clonmel increased the level of specialism and accordingly reduced the ability to interchange staff.

*But you see it's going to be really different over there whereas over here casualty and clinic nurses change around, over there if you're a casualty nurse you're a casualty nurse and vice versa. There is no going from one place to another unless you put in for a transfer (Cashel Support-service pre-merger).*

*When I was there you were always just a number and you were sent to a ward and you would just have your patients to look after (Cashel Patient-carer (4) pre-merger).*

Both Clonmel and Cashel staff also feared that the operating procedures would make the new hospital more inflexible and that it would be increasingly difficult to have the same level of work interaction as in Cashel, particularly in respect of access to management and a voice in decision making.

*Our [manager] here has an open door policy, you don't have to make an appointment if I have a burning issue I go and see her but if I need to see a [manager] in Clonmel .. what I hear is that you make an appointment through the secretary, you can't pick up the phone and talk to [manager] but maybe you can, maybe I'm being misinformed (Cashel Patient-carer pre-merger).*

*If we feel that they are encroaching on our space for any service for example if we needed a baby to have a CT scan but surgery had a patient lined up for that and if we had to wait until the next day we might feel angry. That might never happen but there might be a bit of animosity between the two (Clonmel Patient-carer (1) pre-merger).*

Post-merger the attempts to homogenize work processes paid off as the workflow operated effectively and few significant issues emerged. Where issues did emerge they related to aspects of the workflow such as not getting stores or medical records in a desired time frame rather than significant patient-care problems. Overall the outcomes suggested that while potential difference existed they were not significant. Staff members were willing to acknowledge the difference and to move forward to resolve them. Consistently, staff referred to a time dimension in resolving any problems that emerge.

*Yeah, there are two different [admission] processes in place, there were two different processes in place. And there is almost a third process now since the two have come in, we really haven't settled in yet properly because there's still mistakes and errors happening, patients aren't getting appointments and stuff like that. I think it's because the systems aren't robust enough yet and they will have to emerge and evolve a bit better you know (Cashel Patient-carer (1) post-merger).*



*I do (think working relationships have changed) because I think there is a lot more tolerance and a lot more changing over of different services from surgical to the medical. There are referrals now going from medical into surgical and surgical going up to the medical floors. And for the most part I think it is working quite well between the two services (Clonmel clinical-care post-merger).*

The general positive feeling was on occasion punctuated by negative comments or a sense that the hospital was not operating effectively.

*It's a longer and more confusing process for both medical staff and the patients because you don't know where their charts are and you look for the chart and somebody else has gone off with it. It's just all over the place (Cashel Patient-carer (5) post-merger).*

*You see size and everything seemed more organised in Cashel. I suppose it was because the surgical and the medical was separated. Like here everything just seems to be so disjointed at the minute (Cashel Patient-carer (6) post-merger).*

The analysis of the work processes boundary shows that potential differences might have arisen post-merger. Two very different systems operated and there was potential that staff would reject the changes to their way of doing things. Where conflict did emerge, as in the case of 'the book', the integration groups worked around the issues to develop an understanding and facilitate change. Another interesting aspect about this boundary is that while there was substantial activity focused on the work processes pre-merger, it was infrequently referred to in the pre-merger interviews. In contrast post-merger the boundary was more identifiable and frequently noted. Perhaps this confirms the point that behavioural boundaries become sharper in the minds of staff when they are experienced.<sup>58</sup> Once again however a level of confusion with different work

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<sup>58</sup> Perhaps identification of physical boundaries are more frequent because they are more visibly evident, you see a building, but in behavioural boundaries you must experience the behaviour before you understand the difference.

practices was possible although the management interventions tended to reduce their impacts.

### 8.2.2.3 Team Behaviour

The team behaviour boundary is differences in staff interactions which occur within their team structure. Behaviour involves the way staff relate, communicate and work together.

Similar to the financial services study, the two hospitals each conceived a clear ‘family environment’ with family supporting relationships.

In Cashel there was substantial concern pre-merger about the protection of these family behaviours (and values).

*Well it's a small hospital so everyone kind of knows you, people know me for years coming in and out of here. It's a nice friendly place, everyone in the hospital knows each other and we know each other's form, who we can blaggard<sup>59</sup> with and who we can't! (Cashel Support-service pre-merger).*

*We work here very much like a small family, we have the arguments and the hassles but we are very united to the point that we have our meetings nearly casually and informally. We have a very informal setup in many ways but it has always worked well (Cashel Care-management pre-merger).*

The Cashel staff contrasted this atmosphere of family and friendliness with a sense of the impersonal in Clonmel. Confusion over what this would mean to the work interaction and the relationships between staff was present. These fears were evidenced by references to ‘being detached’ and to ‘the individual.’

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<sup>59</sup> local term to mean engaging in joking and sarcastic behaviour



*The whole part of being in a bigger organisation, could that friendly atmosphere be totally sustained? I don't know. It's not that we know people on a personal level over here but I think that it's going to be more detached..... It's definitely friendlier here. I've heard and I'm only going on what I'm hearing but I think you could be hard-pressed to find a smile over there (Cashel Administrator pre-merger).*

*It really is like a small family here and everyone knows each other but when we go over to the larger hospital we won't have that. We mightn't know the staff working in the other wards (Cashel Care-assistant pre-merger).*

Clonmel were less concerned about losing existing relationships within their team structures. Once again however there was substantial concern over the need to integrate activities and the potential trauma that would be inflicted on the Cashel staff arising out of the integration into a larger and more formalised hospital.

*Here is bigger, so that definitely does impact compared to Cashel. The perception would be that Cashel is a lot friendlier. It is purely because it is a lot smaller but you get to meet people more together there whereas here it is spread out a bit more. People are probably as friendly here but you don't see them as often. It is just the size (Clonmel Patient-carer (2) pre-merger).*

In Clonmel the phrase family was often used to describe the Clonmel hospital with the term 'homely' referring to Cashel. The connotations of these words place an interesting juxtaposition of values and strongly underpin the confusion that exists. Clonmel view themselves as the correct size to be a functioning modern 'family' unit and that Cashel had not made the transition to a functioning family size (being 'cosy'). Cashel however also saw their size as the correct family unit and that the Clonmel hospital has grown too big (being 'impersonal and uncaring'). This is a relative argument; any size could be perceived to be too large or too small relative to any other size. The point is further relevant to the financial services study where a similarly divergent view of family existed.

Branches of widely differing size felt any size larger than theirs diluted the family atmosphere. Another juxtaposition of ideas between the hospitals was the impression of size. Clonmel staff often referred to their hospital as 'not big' as opposed to Cashel which was small. In contrast, Cashel referred to Clonmel as large. The continuum of large to small and the relative positions of the hospitals on it provide a means of codifying, in the minds of each group, an implicit value set that locates both their hospital and the other hospital in favourable and unfavourable terms.

*Just from hearsay there seems to be a very good atmosphere in Cashel. It is smaller and more intimate whereas here it is bigger. I would think that the service here might be a bit more efficient..... it is obviously going to be bigger so you are going to have to make a better effort to get to know people and to welcome everybody. It won't be as homely maybe as it has been [in Cashel] (Clonmel Administrator (2) pre-merger).*

*I have not worked in Cashel, but I would think this hospital is bigger. It is not as close-knit as Cashel would be. We would certainly have expanded a lot here over the years. Cashel was the hospital that was going to close so it did not expand. I would say definitely from hearsay that Cashel would be smaller, friendlier, and more homely but when you expand you are going to have to accept that you are going to get bigger (Clonmel Patient-carer (4) pre-merger).*

Post-merger diverging views on whether the relationships between team members had developed in a positive light existed. Some Cashel Staff consider coming to work a *drudgery*<sup>60</sup> compared to the great atmosphere that previously existed in Cashel.

*I work as [job] so I go throughout the hospital and already this morning, what time is it? I have witnessed two rows, a nurse crying, a doctor and relative having a row and I have only been here four hours..... I would find, now maybe I shouldn't be saying this but "that's not your job". You help somebody and you could get ate<sup>61</sup> for it because that's not your job. You do something that's not on your [remit] and it's "what did you do that for, that's not your job" and it's very hard because we*

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<sup>60</sup> Cashel Patient-carer (5) post-merger

<sup>61</sup> Meaning 'get given out to.'



*weren't used to that you know.....the unfriendliness, just removed. Everybody seems removed from each other. I'm sure on the wards where people are working closer together they have their friendships or whatever but you don't see it (Cashel Patient-carer (5) post-merger).*

*It's the workload, we are more cut off because we are so busy we just don't get time to see our colleagues in other parts of the hospital. Whereas before during the day you might have had five or ten minutes to just catch up with people. It's just so busy now. There isn't that same sort of.....and its bigger now. It has gone from maybe 4 or 5 to 11 in my department so you don't have that same camaraderie maybe that you would have with a smaller number (Clonmel Administrator (2) post-merger).*

These negative comments however contrasted strongly with a more positive outlook from some staff.

*I suppose we have integrated very well. The staff here welcomed us and they were very cooperative, very helpful (Cashel Clinical-care post-merger).*

*We have had several team building sessions. We would have had courses and everyone mixes, get on well with one another. Even if we are having a night out every one turns up (Clonmel Patient-carer (3) post-merger).*

A clear distinguishing factor in the discourse of those who felt more positive about the extent of team relations was the responsibility they accepted for trying to get involved in activities and relationships.

*..we had a dinner the other night; it was a hen [party] crossed with something else. Anyway I rang up to find out if any of the other men were going because I put my name down because this was to do with [unit] and I'm the only man except for the doctors that works there and as one of the girls, the secretary said when I asked her was the doctor going, "what are you worried about, you are nearly a nurse anyway". So that goes to show you that you can either get involved or not. You can mix in and get on well with them or you can stay out (Cashel Care-assistant (2) post-merger)*

The team behaviour boundary is consistent with the financial study and confirms the boundary type provides potential for conflict. Some examples of conflict did in fact emerge and not all members of staff post-merger were satisfied with the

new working relationships. However, once again the boundary did not become sufficiently problematic as to cause problems within the amalgamation.

#### 8.2.2.4 Customer Service

Customer service is the relationship that each unit has with the client. In the hospital study it is probably more relevant to refer to this boundary as patient care and consider it in terms of how they interacted with the patient and provided the appropriate patient welfare.

Cashel considered their pre-merger patient care to be of the highest standards. They did not however perceive any difference in how either hospital would behave towards a patient except in so far as Clonmel might consider the patient *'just a number.'*<sup>62</sup>

*I don't know until I get there but I would hope that we could just slot in, work together, respect each other and at the end of the day strive to have patient care number one (Cashel Care-assistant (3) pre-merger).*

*Care wise both hospitals are excellent having had experience with family members as patients and I have never heard them complain and they would, I'd be the first to hear it. They both have a good ethic of care really (Cashel Care-management pre-merger).*

Cashel staff felt they went that bit further for patient care and often quoted as an example the flexibility their canteen facilities provide in dealing with patients and providing them with food or drinks.

*I will give you one example of Cashel hospital the amount of sandwiches and teas that we hand out in casualty alone. In most hospitals this wouldn't happen because the catering system wouldn't be able to do it but if we have a patient who has been here for hours we will give them tea and sandwiches. You would be surprised at some of the patients, it*

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<sup>62</sup> Cashel Patient-carer (4) pre-merger



*was only the other day that a patient came up and said that they had to wait for a taxi and could they have a cup of tea. It's almost expected now. I think there is that bit extra and go a bit further here (Cashel Care-assistant pre-merger).*

*We also like to make sure that the family of long-term care patients are looked after as well. An example of this would be that two weeks ago we arranged a small birthday party on the ward for a terminally ill patient and her family and kids came in and she was just delighted with it. She died the following Monday. I hope that we get the time to do that over in the Clonmel hospital but I would worry that it's going to be too busy for it (Cashel Care-assistant pre-merger).*

Clonmel staff emphasised the patient care value that the two hospitals coming together would create, *it will be good for the patient* (Clonmel Patient-carer (1) pre-merger). Clonmel's perception of quality in patient care was similarly high for both hospitals.

*[Cashel] very much have their patient focus at heart. Very similar from my point of view. They give an excellent service and we do too. There are things that we can work with in tandem. The same ethos across the board and when they realise we have the same it might be easier for them (Clonmel Patient-Carer (5) pre-merger).*

*At the end of the day the patient is the main focus. I would say patient care is 100% on both sides (Clonmel Support-services (3) pre-merger).*

When the two sides came together the patient care boundaries did not provide any significant conflict. The ethos of both hospitals to patient care was clear.

*I suppose in [this department] I think people have come to understand us and they have had patients come into us who have been sick and these patients have gone back out again and I think that builds up a topic for integration and communication if nothing else you know when you have patient care threaded through the whole hospital. I think it may have helped us integrate more than other departments (Cashel Patient-carer (2) post-merger).*

*Really it is for the patient, it is a good move for the patient. .... Everything is centred around the patient (Clonmel Support-services (2) post-merger).*

However, the canteen provision was held up as an example of a reduction in patient care. Staff of Clonmel origin continued to articulate the improvement in service provision and the benefits to the patient.

*I mean the menu is the menu here whereas we had the run of the kitchen if somebody didn't want something or if they wanted something different if they didn't feel like it, we could get them anything they wanted. That doesn't happen here (Cashel Care-assistant (1) post-merger).*

There was a sense of loss in Cashel about the patient care that was provided and the affinity with the ethos that prevailed in the smaller hospital set-up.

*There was a huge affinity by patients with Cashel; I know that going back the years. They had a huge love for the place and you know without casting any aspersions on anyone, they loved to be in Cashel. The patients loved the atmosphere; they felt cared for, they felt well looked after. It was a closer knit community, you got to see the doctors more often, the relatives got to see the doctors as they passed in and out. It was a smaller, closer, more comforting environment for the relatives and patients (Cashel Patient-carer (2) post-merger).*

Both hospitals had a clear focus on patient care and this should be expected for a health care environment. The boundary did have some significant differences and concerns about the maintenance of patient care post-merger but these did seem, on the whole to dissipate quickly, post-merger. It is important to note that the logic of the merger was to reduce clinical risk associated with separate services and to improvement patient care and patient outcomes. It would therefore be expected that patient care would be seen as a common bond that ties together both organisations as well as the vision for the new hospital. The converse of this is that if a boundary did emerge and become problematic it would undermine the entire logic of the amalgamation. The perception of staff that patient care had improved was strongly evident in the questionnaire data with 77% of staff agreeing with the statement *"The Hospital provides better services now than*



*when the services were on separate sites*” compared to only 13% who disagreed. The Cashel group did however report a lower average mean (3.91) than the group as a whole (5.66) and a larger standard deviation (1.93 as opposed to 1.71). This variation in results arises as the Cashel group had a greater variation in response rates with a more equal distribution around the mid-point. Similar scores were reported for agreement with the statement “*Our service continues to improve all of the time*” with 74% agreeing to some degree with the statement and only 16% disagreeing. Again the Cashel group scores reported a lower than average mean (4.29 against an average of 5.24) and a higher standard deviation (2.03 as opposed to 1.73). Finally, support was also given to the statement that “*We have achieved a high standard of service since the amalgamation*” with 71% of staff reporting agreement.

### 8.2.3 Cognitive Boundaries

Cognitive boundaries were described as the ways in which people think about things and make sense of events and actions in their work. The financial services study uncovered two cognitive boundaries:

1. Work beliefs,
2. Belonging.

#### 8.2.3.1 Work Beliefs

Work beliefs are the underlying assumptions about how the work environment operates and the value sets that underpin action and understanding. The financial study showed strong differences in the beliefs and values held by each side for similar concepts, such as the definition of good service. A strong unifying value

system existed in the hospital study. From early in data collection a strong focus on the patient was evident. The work of the executive transfer team regularly addressed patient-care issues and the hospital was consistently investing in patient quality improvement, i.e. new staff appointments in clinical risk, implementing the accreditation review etc. The development of a mission statement within the hospital which involved data collected from a staff questionnaire and from two separate focus groups clearly showed the consistency of values between the two hospitals. A questionnaire applied in the summer of 2005<sup>63</sup> asked respondents to list the values that they felt were important for the new hospital. The top values that emerged were quality of service (64%<sup>64</sup>), high morale, (45.3%), empathy with others (41.3%), equity and access (30.7% rated), and promote learning (28.3%). Strong consistency was also evident in the preferred mission statements. 80% of all respondents rated the statement “*The hospital places the patient at the centre of all its activities and will ensure a quality care environment for the patient*”. Focus group<sup>65</sup> data confirmed the importance of patient care and the quality of the environment as key values across both hospitals. The key values for each hospital that emerged from the focus group discussion are given in Table 8.1.

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<sup>63</sup> Note the comments in the methodology in respect of the low response rates to this questionnaire.

<sup>64</sup> The percentage refers to the number of times the category received a preference vote (1 through 5)

<sup>65</sup> The hospital commissioned two focus groups which were implemented under my direction and supervision but which did not form part of the thesis design.



Table 8.1: Key values identified in focus groups

Cashel	Clonmel
Care and patient focus	Patient centred
Dignity and respect	Dignity and respect applied to patients and staff
Best practice and quality	Quality of service
Inclusiveness	Open and participative
Sensitivity to individual needs	Equality
Recognise the role of staff	Appropriate hospital environment to develop services and staff
Recognise multiple users	Education for all

Table 8.1 clearly shows that there was a high degree of value congruity that existed and that the questionnaire data collected was consistent with the opinions of the staff (this gives added reliability to the outcomes of the questionnaire especially given the low response rate of the questionnaire). The importance of patient care was also evident in the interview data and this cut across both hospitals.

*We are all here to work for the one cause which is the patient regardless of what your profession is: we are all equals in that sense (Cashel Administrator pre-merger).*

*I have worked on wards and seen nurses and doctors; they are passionate about what they do. They would not be there if they were not. They want to save lives (Clonmel Administrator (1) pre-merger).*

*We are all here for the betterment of patient care, for the good of the service (Cashel Patient-carer pre-merger).*

*The job is very satisfying because you are helping people at all times. That's the most challenging thing. Seeing patients improving and going home and all that, knowing you are playing some part in it (Clonmel Support-services pre-merger).*

Tensions were however evident, particularly in Cashel. There was a fear that the amalgamation would have an impact on the values set. The fear was that certain

characteristics of the new hospital would make it difficult to maintain the values. This was often difficult for the staff to express, pre-merger, and a clear sense of confusion existed.

*I'm hoping the standard of care won't change, if anything it will go up. No I don't think there will be an [pause]. The patient will experience the same thing. I mean obviously patient care, because you are going into a bigger set-up there might be less of the personal touch than what you get here but as far as standards of care everything should be the same (Cashel Care-assistant pre-merger).*

*I believe that the people within the organisation expect us to change to deal with the systems that exist, they don't expect the systems to support the patient services. At the end of the day it's the patient services that's important and an example of that would be the potato shed<sup>66</sup> and the medical records. We are not to ask for those charts because they are out there and they are not accessible so we shouldn't ask for them. The fact that we might need them and the patient's safety might be at risk you know. So I think certain people have their eye on the wrong ball (Cashel Patient-carer (1) post-merger).*

In addition to the patient care the Cashel hospital linked their level of service to the size of the hospital and assumed that the level of care is better in smaller hospitals.

*I think here that we have like a holistic approach. We provide special care and attention here because we are a smaller hospital. It's like everything you know, patients would turn around and say 'God you would never get this in a bigger hospital'. You could be sitting there on a trolley, like I have seen it myself recently when I went to a much larger regional hospital and I just thought to myself there's a huge difference between what patients can expect and get in the likes of a smaller hospital than a larger one (Cashel Patient-carer (3) pre-merger).*

Another dimension to Cashel's beliefs was the notion of what a family meant in the context of work. The notion of family was related to 'looking out for each other' and providing a 'supporting' environment.

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<sup>66</sup> The 'potato shed' was a term for a building that existed on the Clonmel campus and which had been converted to hold medical records.



*What I know myself and I am talking about nurses now more than any other group but here there is a team spirit and we look out for each other. We have a lot of maybe older staff; they wouldn't be the same clawing at the ladder for ambition, as in clawing over each other (Cashel Care-management pre-merger).*

Post-merger the Clonmel group espoused the continued focus on patient care and emphasized the similarities between the two groups that have allowed them to come together successfully.

*As in every hospital everything done here is for the patients. You have all the clinical specialists under one roof. We have a great service. The best care, the cardiac disease all them people that are under the one roof. Oncology and everything is here for them. It is great to have everything here (Clonmel Administrator (3) post-merger).*

*The staff have made the effort to try and make it work both sides, us and them. And it is not an us and them anymore it is all of us together. We work well together. I think that is why it has worked. We had to do it, it had to be done and we all knew that for the greater good (Clonmel Patient-carer (5) post-merger).*

Driving against these ideals of 'patient care' and the 'greater good' was a theme of 'busy' and 'lack of staff' which reduces the potential to deliver the patient care and impacts on the family values that existed in the hospital as it stretches people and resources.

*It's just very very busy, if you walk there is loads of people around. It's just very busy. The volume of work has increased, the clinics going on. It's a busy hospital now (Clonmel Administrator (2) post-merger).*

Cashel staff reported similar issues with the impacts of size and professional structures impacting positively on their perceptions of what could be possible.

The size of the new hospital and its busyness also had negative consequences for the patient care side.

*I suppose it was one unique thing that we had in Our Lady's Cashel that patients always got very good patient care and I think that's one thing that Our Lady's Hospital Cashel staff get very frustrated about. You can't*

*give that care when you don't have the staffing levels and you're not providing that care you know (Cashel Patient-carer (6) post-merger).*

*It's just so slow to get things done you know and that's frustrating. Like the patient has always been the priority in Cashel, it's the system here - if it's OK on paper sure we will get it right eventually. You can't take that at all and I know that paper has to be right as well but the paperwork can wait a little bit longer than the patient who needs your help there and then (Cashel Care-assistant (3) post-merger).*

Finally, the commitment of staff to maintaining their values was noted in a number of interviews.

*I have purposely foraged out stores, purchasers and pharmacy and got to meet the people face to face because I couldn't be doing with just a name on an email or just a name at the other end of the phones. That would be just too cold (Cashel Patient-carer (2) post-merger).*

*But still I suppose if we didn't try and make the effort and have the positive outlook in the early days we would never have achieved anything. Like I mean if we were standing with our arms folded glaring at new people coming down the corridor you can't be like that, you have to be there with smiles on our faces telling everyone they were welcome. And we wanted to be like that (Clonmel Patient-carer (5) post-merger).*

As in the financial studies case identifying values and the potential differences between the espoused value sets of two different groups is complex. Often, the differences are not really understood until they come into stark focus. In the hospitals there was some tensions pre-merger concerned with the fear of values changing in the new hospital set-up. These fears did not appear to occur in practice. This could reflect either the closeness of the values that existed or that any issues that emerged (or could have emerged) as problematic were quickly resolved and never got the opportunity to develop. The relationship between the physical, behavioural and cognitive boundaries may also be relevant in this respect. It is clear from some of the behavioural boundaries that they only became evident when the groups were exposed to a particular behaviour. Even



though the two groups espoused strong support for the same value set, the translation of those values into practice might be different in the two hospitals. This was evidenced by regular comments such as ‘medical and surgical patients are different’ or that there is always a tension between ‘surgical and medical.’ This suggests that there may be some underlying differences in the belief systems, for example a sick patient will be handled differently from a person attending for a routine operation. However, differences in values did not emerge in the post-merger hospital.

#### 8.2.3.2 Belonging

Belonging is the sense of identity organisational members get from their association with the particular organisation. Hospitals have unique characteristics in this regard. As public and national organisations, hospitals are staffed by professional categories of people, such as doctors, nurses or clinical specialists. These categories create professional identities as well as organisational identities and increase the opportunity for mobility while maintaining identity. However, this is not uncommon in commercial organisations as well, for instance accounting or legal professions.

The belonging category was very evident in the processes that built up to the amalgamation at both the organisational and professional levels. The staff relied heavily on staff associations and unions to support their positions in the lead-up to merger day. The Cashel hospital named ‘Our Lady’s’ was honoured by naming one of the wards in the new STGH (staffed by transferees from Cashel) after it. The staff questionnaire applied in 2005 showed extremely strong

identification of Cashel staff with the hospital.<sup>67</sup> Similarly that questionnaire showed strong identification existed in the Clonmel group to South Tipperary General.

It was clear from Clonmel staff that membership of the hospital created pride for them.

*I am proud to work here, I am proud of my achievements. There is a certain amount of recognition with being a CNM 2 from those senior to you. They could come to you for advice (Clonmel Patient-carer (1) pre-merger).*

*I would like to think that I am contributing something. I take pride in my work. I would like to think that I am part of a unit that is providing a good service to south Tipperary (Clonmel Administrator (2) pre-merger).*

*It is my workplace; it is a place I am very happy to be. I enjoy working here. It means a lot to me, it is a place I spend a lot of time. It has always been a pleasant place to be (Clonmel Patient-carer (4) pre-merger).*

The hospital was also seen as *a second home (Clonmel Support-services (3) pre-merger)* where *people watch out for each other (Clonmel Patient-carer (5) pre-merger)* and where the focus is on developing both the hospital and the person (*everybody is studying Clonmel Patient-carer (5) pre-merger*).

The same theme of pride was also strongly evident in the pre-merger Cashel interviews.

*There is a sense of pride because people know you when you go out on the streets. I had a case the other day, someone died 4 years ago and this woman met me on the street and she said she remembered me from 4 years ago when her husband died. .... You could sit down the pub and all of a sudden get a drink in front of you and it's the thought that there are people who remember because obviously they were very ill and even close to dying or even for those that you helped to die, There is a great*

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<sup>67</sup> Response rates for this survey were low at 10% so these statistics must be taken with some reservations.



*sense of pride when you work for a hospital (Cashel Care-assistant pre-merger).*

*I'm proud to say that I work in Cashel, I feel I'm part of a team that delivers a good service (Cashel Patient-carer pre-merger).*

*I have always been very proud to say where I work, what I did. I have enjoyed working with all my colleagues (Cashel Care-assistant (3) pre-merger).*

In addition to pride, two other themes strongly emerged from the Cashel data.

The first of these was the sense of family ties linked by references to camaraderie, home and family.

*Cashel really is like a home from home, it's like a small family. Everybody knows each other from the kitchen staff to the consultants (Cashel Care-assistant pre-merger).*

*There is a very good feeling at work, a very good camaraderie and working together and getting things done (Cashel Patient-carer pre-merger).*

The second theme was the sense of ownership or community that the staff in Cashel felt. This linked the hospital to the external community, its heritage and its people.

*I remember when I started the matron asked me what age I was when I came for the interview and she said thanks be to God you wont run away from me. Normally it would be only schoolboys who would be here today and gone tomorrow. You see I was actually born here in the hospital and I only live 200 yards away from the hospital (Cashel Support-service pre-merger).*

*Most of the staff live within the catchment area of the patients so there is a real sense of ownership and care that they know the people that are coming in, some of them not all of them of course. But there is a local feeling to it as much as, there is a personal feeling to it because of knowing so many of the clients. When you are in a small place everyone knows each other for good or bad (Cashel Care-management pre-merger).*

The Cashel group also showed concerns about losing their identity and the potential loss of respect for the person fearing that they would become a '*number rather than a person.*'<sup>68</sup>

*I feel that we are going over and they feel that we are just nurses from Cashel and they don't have very much respect for us, that we are just another number (Cashel Patient-carer (4) pre-merger).*

*I mean it's a small close-knit hospital here where everybody knows everybody and now we have the feeling that we are going into a space where we are never going to see one another again (Cashel Patient-carer (3) pre-merger).*

Pre- and post-merger identification measures were collected at the end of cycle 2 and cycle 4. The identification scores, pre-merger, indicated that the levels of identification differed in each hospital. There was a strong affinity to each hospital of heritage. The Clonmel group also identified strongly with STGH while in contrast the Cashel group reported very low scores for identification with STGH (see table 8.2). The methods chapter indicates that the responses to this questionnaire was poor and its ability to draw statistically relevant conclusions is limited, it none the less does provide a feeling for the perceptions on the ground. Feedback to the staff and the discussions with management also gave support to the sense that the data is valuable and reflective of the position in practice.

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<sup>68</sup> *Cashel Care-assistant (3) pre-merger*



Table 8.2: Mean scores on identification pre-merger

Statement <sup>69</sup>	STGH <sup>70</sup>	Cashel
I see myself as being from (named hospital of heritage)	5.18	6.35
I am pleased to be a member (named hospital of heritage)	5.83	6.82
I feel strong ties with (named hospital of heritage)	5.19	6.47
I identify with other members of (named hospital of heritage)	5.53	6.59
Being a member of (named hospital of heritage) is important to me	5.42	6.11
I see myself as being from South Tipperary General Hospital	5.74	2.76
I am pleased to be a member of South Tipperary General Hospital	6.10	3.00
I feel strong ties with South Tipperary General Hospital	5.40	2.82
I identify with other members of South Tipperary General Hospital	5.98	3.61
Being a member of South Tipperary General Hospital is important to me	5.98	3.11

Post-merger the conditions changed somewhat and both groups began to identify with the STGH. Table 8.3 gives the corresponding scores for 6 months pre-merger.

Table 8.3: Mean scores on identification post-merger

Statement	STGH <sup>71</sup>	Cashel
I see myself as being from South Tipperary General Hospital	5.63	4.57
I am pleased to be a member of South Tipperary General Hospital	5.75	4.76
I feel strong ties with South Tipperary General Hospital	5.25	4.02
I identify with other members of South Tipperary General Hospital	5.50	4.45
Being a member of South Tipperary General Hospital is important to me	5.47	4.51

The comparison of table 8.2 and table 8.3 show that the level of identification among STGH staff dipped marginally but is still very strong post-merger. The Cashel group’s level of identification however did increase and a negative pre-merger sentiment shifted to a positive sentiment post-merger. Again it is important to note the validity of the pre-merger scores given the response size. A key point however is that the level of identification with the hospital appears to have developed positively among the Cashel staff. Table 8.4 brings compares the

<sup>69</sup> Based on a 7 point scale  
<sup>70</sup> For table 8.2 STGH represents all staff who were not located in Cashel.  
<sup>71</sup> For table 8.3 STGH represents all staff who described themselves as not originating a contract of employment in Cashel.

findings across the two time frames (note however the difference in populations) which shows the improvements in identification post-merger.

Table 8.4: Mean scores on identification for Cashel pre- and post-merger

Statement	Cashel Pre	Cashel Post
I see myself as being from South Tipperary General Hospital	2.76	4.57
I am pleased to be a member of South Tipperary General Hospital	3.00	4.76
I feel strong ties with South Tipperary General Hospital	2.82	4.02
I identify with other members of South Tipperary General Hospital	3.61	4.45
Being a member of STGH is important to me	3.11	4.51

In support of this finding the interviews with staff suggests that their fears did not materialise post-merger. Although short staffing and the pressures of setting up the new hospital did create a number of problems. For example, some staff was transferred over to Clonmel on a temporary basis and as jobs opened up in Cashel, with the development of services there, they had the opportunity to return. Many did take this opportunity and returned.

*I think if you look at the new part open up in Cashel, the interviews that have just happened, I think out of 15 carers that have come here, I think there are only 4 or 5 are definitely going back. Now that says in itself that people are happy here. I know that a few that didn't want to come I don't think there is any way they would go back [now]. .....I know that people still aren't happy. And at this stage they are not going to be happy. If they haven't settled in now they never will settle in. Some people just haven't bothered and they are too.....whats the word thay are too Cashel....they have always supported Cashel and they always will support Cashel so they are going to have a problem adjusting in that case. They will be looking for any small thing that might go wrong (Cashel Care-assistant (2) post-merger).*

The feeling of belonging to STGH and being part of the hospital developed in the Cashel group although it, in many instances, took time. The focus on patient care appeared to have a direct link to the staff's sense of belonging. Pride in the hospital and its communities came from the delivery of a patient centered service. Individuals were proud to deliver on the care element although the



Cashel staff maintained artefacts of the old hospital, (e.g. they named one ward Our Lady's). Notwithstanding the strong sense of pride, there was evidence that the transition to belonging had been traumatic even for those who had made a successful transition. The personal contribution that each individual undertook to be part of the new hospital was clearly evident.

*Really the pride is for what you are doing and how you are doing it. I do the same job here as I would have done in Cashel: it doesn't matter where I am that patient still wants the same. I didn't go into Cashel because I liked the building (Cashel Care-assistant (2) post-merger).*

*Well I make myself be a part of it [STGH]. Nobody has been rude to me in any way but I am here to do my job and I take my work seriously and I give it my best and I go home when I have my day's work done. I'm assertive, I can stand up for myself. .... I'm still part of a team in a caring profession (Cashel Care-assistant (3) post-merger).*

*I haven't reached that stage yet [belonging to STGH]. I don't have the same dread I had walking in the door as I had say up to the end of February. Where I just thought there were so many things to be fixed and so many issues to be solved that I just wanted to just run away. I don't have that feeling anymore I'm OK coming in in the mornings (Cashel Patient-carer (2) post-merger).*

The move, once completed also opened up the vista of new opportunities and it took time for this realisation to emerge.

*I believe that coming here has been better for me. I mean through the people I know and that, there will be more opportunities ahead. And the thing about it also is that if you want to include yourself and get involved, that if things do come up that you are not aware of they will be mentioned to you. They will realise that you want to and then they will include you into it, if anything comes up they will think of you (Cashel Care-assistant (2) post-merger).*

As with other boundaries there were examples of staff from Cashel who did not identify with the new hospital or its work. These staff used physical or behavioural boundary types, for example the team members, or the work relationships to justify that their work environment had changed and that they

could not identify with the new regime. These staff held onto old artefacts and beliefs.

*Well I used to love going to work in Cashel and it was great and everybody knew everybody and everybody helped everybody. I have to say coming in here is drudgery..... I just come in and do my work and go home. I don't think about it really as being a part of STG or that I even want to be a part of it. I don't feel a need to be a part of it. I don't necessarily need to be a part of it; I just come in and do my work (Cashel Patient-carer (5) post-merger).*

*A lot of the staff were lovely but I suppose you have maybe the Cashel staff and the Clonmel staff in the beginning but people like we weren't long being told you're not in Cashel anymore. The only good thing is that it's nice that our ward is called Our Lady's ward, it's just something that we still have from Our Lady's in Cashel..... I suppose my heart is still in Cashel and I suppose it's like everything I'm counting the weeks now to going back. I'm part of this ward you could say but I can't say I'm part of STG because I could go into another ward and nobody would know who I am (Cashel Care-assistant (1) post-merger).*

Clonmel staff post-merger continued to affirm their identity as part of STGH using similar themes of pride and engagement to support their perceptions.

*I was involved in the amalgamation of the emergency units so I would have been involved with the staff and bringing areas together with the A&E consultant. So I suppose that transition was huge for me and it amalgamated very well. So I do feel part of it (Clonmel Patient-carer (3) post-merger).*

*It is the same as when I worked in St. Josephs. You always take pride in your job, and make sure that your work is done to the best of your ability (Clonmel Support-services (2) post-merger).*

There was more of a sense of continuity among the Clonmel staff and that while the hospital had developed it was fundamentally the same hospital. This is again consistent with the strong sense that the merger was about improving the patient care through the provision of additional services in Clonmel.

*No I don't think so (identity changes as part of merger). Because I don't think let's say, I am still doing the same job that I was doing prior to the amalgamation so that would not have changed my identity. I would still have been treating patients over in Cashel and that has now kind of*



*transferred to here. I would think that I am still the same..... It means that I am part of a new service, a better service hopefully that provides better patient care and try and help develop services further from here on in (Clonmel clinical-care post-merger).*

*I suppose really I don't feel any different to what I did before we amalgamated. I was in the lucky position that I knew a lot of the key staff that were coming over so my position really had not changed at all (Clonmel Patient-carer (2) post-merger).*

Some Clonmel staff also had difficulties with the amalgamation and felt their sense of belonging had been damaged as a result.

*I felt a bit like a very small fish in a very big pond. And I think seen as I have been working here a long time and I have been very loyal member to the institution I felt really a bit miffed... It wasn't the comfort zone I expected, it wasn't as buffered as I thought it would be. I was very optimistic about it and I was a bit disillusioned when we were going through it then to see how it ended up being very stressful. I would have listened to the news years back and hearing about the big hospitals in Dublin doing it so I knew the staff found it very difficult and they were very disgruntled and upset and I kind of thought it wouldn't happen here because it is a smaller level but sure I was fooling myself really you know. As I said hindsight is a great thing (Clonmel Patient-carer (5) post-merger).*

The sense of belonging was strong in both hospitals. The capacity for conflicts to emerge from this boundary is evident. If cognitively, groups cannot create a common sense of being then they will have difficulty relating to one another. The data shows however that this did not occur and that a sense of belonging to the new hospital did develop, even though it was at times problematic. Not everyone could make the belonging transition and some staff either returned to Cashel, left the hospital all together or showed levels of disillusionment. The identification scores from the questionnaires give weight to this transition. There was clearly a challenge to the identity of staff and a tension created that challenged existing identity. The vision of the hospital, its commitment to professionalism and the patient, assisted staff to overcome the identification with

the hospital of heritage and to concentrate on the professional values important to a healthcare professional.

#### *8.2.4 Conclusions on Application of Boundary Framework to the Hospital Study*

Strong commonality between the boundaries in the financial study and the hospital study can be seen to exist. Similar potential for salient differences to develop clearly exist in the hospital study. In many cases however they did not actually create conflict. What is more important about the hospital study is that, while some boundary types did not exist in the case new types were not present. In that respect the framework developed in the financial study provided a robust way of examining the potential differences and planning actions to avoid conflict. The support provided in the hospital study for the boundary types identified increases confidence in the framework.

### **8.3 Comparing boundaries across the financial services and hospital studies**

The preceding discussion on the boundaries in the hospital study confirms the potential for each type of boundary to create tensions within the amalgamation. Tables 8.5 to 8.9 relate the boundaries developed in the financial study to the experiences in the Hospital study. With the exception of the ownership boundary, which is not relevant because of the state ownership of both hospitals, all of the boundaries identified in the financial services study have parallel categories in the hospital study. It therefore gives strong support to the theoretical position



that boundaries can be categorised and considered in terms of a defined type of tension that each category creates.

Table 8.5: Comparison of physical boundaries in the financial and hospital studies

Type of Boundary	Cause of Boundary	Tension Created by Boundary	Example from the financial services Study	Examples from the Hospitals Study
Job description	Differences in the context of work i.e. terms and conditions	Unfamiliar Structures: What are the structures to which staff are working	References to the rota-day versus overtime for working late on Thursday.	References to on-call duty and start-times
Product Set	Differences in the range of product and services offered	Unfamiliar Products: Understanding the new products or services	References to the 'skills gap' in product knowledge between the two organisations	References to the type of care needed by each patient type
Location	New premises or altered premises (comparison of old versus new)	Unfamiliar Location: New or different building	References to not knowing the layout of the building or the unsuitability of the building	References to the hospital building age and layout and suitability
Colleagues	Alteration to the existing team structure through the addition of a number of new members	Unfamiliar People: Need to get to know new people	References to the concerns of the team size and getting to know the new members.	References to the concerns of the team size and getting to know the new members
Owners	New ownership structure	Unfamiliar Demands: what is required by new owners	References to shareholder objectives	Not applicable as the hospitals are state owned
IT System	Selection of one IT system over other	Unfamiliar Tools: Need to get to know how systems operate	References to difficulty in adapting to new IT systems	References to difficulty in adopting to new IT systems although less significant in the study
Manager	New manager, which represents loss of gatekeeper and symbol of leadership and power for one group.	Unfamiliar Direction: What does the new manager value and how do they operate within the new power structure.	References to personal loss over the departure of the manager and to the need to get to know how the new manager operates	References to the leadership support of line management and to the loss of seniority

Table 8.6 Comparison of behavioural boundaries in the financial and hospital studies

Type of Boundary	Cause of Boundary	Tension Created by Boundary	Example from the financial services Study	Examples from the Hospitals Study
Personal Investment	Level of personal commitment that an individual is willing to invest in the work/group	<i>Commitment Confusion</i> Creating balance between self and work	Working 'unrealistic' times and working extra to facilitate group cohesion	Staff required to 'pull their weight' and give 100%
Work Processes	Differences in how work is performed and tasks completed	<i>Task Confusion</i> Matching tasks and the way they are performed to meet new job description	Servicing versus selling to the customer	The roles of team members and their flexibility in doing tasks and the level of formality of task design
Team Behaviour	Expectations of behaviour within the team	<i>Social Confusion</i> Operating in new emergent social order and determining the position within that social order	Importance of being a team player and the desire to have good social relations in the new branch notwithstanding 'being wary' of each other	Family style interactions or professional impersonal interactions
Customer Service	Changing customer requirements and interactions	<i>Translation Confusion</i> Translating the products and procedures into meaningful customer interactions	The queue management emphasis in each organisation.	Doing what is best for the patient

Table 8.7 Comparison of cognitive boundaries in the financial and hospital studies

Type of Boundary	Cause of Boundary	Tension Created by Boundary	Example from the financial services Study	Examples from the Hospitals Study
Work Beliefs	Differences in the underlying logic of why the work is performed in a given manner	Sense Challenge: Understand the validity of the other's way of conducting activities	The need to accept that 'being busy' included sales and service. The Retail v the Capital way.	The difference between surgical and medical care
Belonging	Importance of group membership and identity	Identity Challenge: Motivation to feel part of the combined organisation/ let go of the old and accept the partner organisation	Sense of pride felt in the branch and organisation achievements	Sense of pride felt and the importance of being a health professional



## 8.4 Conclusions

This chapter laid out the data collected through interview data collected in the hospital pre and post-merger. The aim of the chapter is to examine the boundaries within the hospital and to examine whether similar boundary types existed as in the financial study. The hospital study reported very similar boundaries, with one notable exception which could be readily explained in terms of public-private ownership. The data suggests that the same types of boundaries occurred in each study. This finding supports the trustworthiness of the theorised categories and individual boundaries for each case group.

To develop the framework the next chapter will address the final part of the third pillar; how boundary salience occurs. It will do this by exploring how within the hospital study groups ebbed and flowed from separation to integration (drawing on the data from this and the previous chapters).

## **9 Discussion on the Hospital Study**

### **9.1 Introduction**

The final pillar of the research design is developing theory from the application of the framework developed in chapters 2 and 6. The contribution that this chapter will make is to explore the tensions that existed in the hospital study and explain how the boundaries translated into salient differences that created conflict within the hospital. From this analysis it will be possible in the final discussion chapter to bring together theoretical insights that will explain how boundaries can be changed during an M&A integration. To deliver this contribution the chapter will:

1. explore how boundaries were drawn and re-drawn within the hospitals;
2. theorise how boundary salience emerged and what strategies existed to manage boundaries within the study.

The outputs of this chapter will form part of the final discussion chapter which will bring together the three pillars of the research design.

### **9.2 Drawing Boundaries**

From early in the amalgamation process the majority of management time and the focus of the executive team were strongly directed toward the creation of common operating frameworks and on the creation of an appropriate physical environment. These two factors (both physical boundaries) were the key artefacts that staff in both hospitals looked to in determining the progress of the amalgamation. Hence from an early stage in the amalgamation process a long list



of 'issues to be resolved' had been created and this list almost entirely related to physical (such as parking, workspace or lockers) and operational terms and conditions (such as on-call duty, uniforms, starting times and patient pathways). Working groups were created to deal with these and resolve any difficulties. The aim was to give ownership of problems and the capacity to resolve them to those who were directly affected by the problem. In this way any issues that emerged had a clear resolution mechanism. This in some part explains the general feeling post-amalgamation that the merger had been successful and that the hospitals had merged and integrated successfully.

Mapping the pre- and post-merger positions, however, shows that success is not as clear-cut as the survey results might indicate. Pre-merger, the Cashel group expressed numerous fears about the size of the new hospital, the loss of identity and the fear that the family values and interaction that underpins that identity would be lost. The relationship between the fears, which are all behavioural and cognitive boundaries, and the actions, which were the focus of the executive transfer teams, mostly physical boundaries, is interesting. Both the staff and management teams expressed issues in physical terms and related them to tangible aspects of the hospital while in contrast they expressed fears in the context of emotions and identity. This implies a tendency to diagnose problems in a way that allows a gap to develop between the problem and the emotional stresses that may underpin those problems. In the hospital case the management directly addresses the cognition of staff by focusing on values and culture. The creation of a mission statement for the new hospital was a clear example of this process. However it was difficult for managers who are primarily task-focused to

deal with these issues. In general discussions on values and cultures were largely omitted from the executive transfer team's formal agenda.

In exploring explanations for the success of the merger we drew on the field of organisational discourse (Hardy et al, 2005; Heracleous and Barrett, 2001; Fairclough, 1992, and Keenoy et al 1997). Paasi (1999) defined national borders in terms of social practice and discourse and shows how discourses at multiple levels influenced senses of regional identity. At the organisational level, discourse draws on the use of language and communicative practices that exist and which can be directed toward collective action (Hardy 2005). Organisational discourse has been shown to shape change processes (Heracleous and Barrett, 2001; Grant et al 1998). For instance, building on existing streams of discourse research Heracleous and Barrett (2001) develop a 'structurational' view of discourse which sees discourse as a duality constituted by two dynamically interrelated levels: the surface level of communicative actions and the deeper level of discursive structures, which in turn are recursively linked through the modality of actors' interpretive schemes (p.755). They found that organisations consisted of 'fragmented, competing and less often complementary discourses' (p.774).

Of particular use to the analysis of the hospital data is Hardy et al's (2005) work on discourse and collaboration. They describe organisational discourse as consisting of three interrelated concepts, discourse, text and conversation. Drawing on the work of Fairclough (1992), Parker (1992) and Philips and Hardy (1997) they define discourse as a set of interrelated texts that, along with the



related practices of text production, dissemination, and reception bring an object or idea into being (p.60). Texts are symbolic representations that give reality to discourse patterns and include speech acts, written documents, artefacts and symbols. Drawing on Ford and Ford (1995), Hardy et al, (2005) define conversations as a set of texts that are produced as part of an interaction between two or more people and that are linked together both temporarily and rhetorically. The hospital had substantial numbers of arenas for conversation to occur across many levels of the organisation, these included the individual level as people interacted in their daily duties, the group level particularly the partnership groups, the management-staff interface (represented in most cases by union interactions), external stakeholders such as the Cashel Action Group and local politicians and government-hospital relations (represented by the funding and resourcing issues). These conversation spaces produced multiple opportunities for text production and for linking existing texts into symbolic meaning. Based on these text and conversations it is possible to look at the success of the merger in terms of two interwoven themes that permeated the discourses that dominated the process. On the one side the, 'change' discourse emphasising the need for the merger to occur because of the improvements in patient care that it would bring and because a modern health system could not support the separation of services in South Tipperary. The clinical risk arising from the separated services was high. This discourse dominated the thinking throughout Clonmel and was evident but less vocal in the Cashel cohort. The second discourse stream, the 'it won't happen' discourse, expressed concern about the state of preparedness for the transfer and that several outstanding issues need to be resolved before the transfer would deliver any additional value

to the patient. It was unfair to staff (and patients) if these issues (such as the remaining services in Cashel) were not resolved. The discourse structure also supported a belief that the transfer could not be achieved until these problems, which were difficult to resolve, were adequately resolved and that consequently the transfer was not really going to take place at all (or at least not in the work-life-span of the existing staff). The surgical services were effective and patients received a good service in Cashel, for example there were no waiting lists. This discourse was common in Cashel but not present at all in Clonmel. Even though this discourse stream dominated in Cashel it was not uniform and a significant sized group believed that the transfer was essential in terms of patient care and hospital survival. Anecdotally, the main source of this discourse was the staff with letters of support and who did not have to (or in many cases want to) transfer. It is not surprising that these letters of support become known, by others in Cashel, as the 'golden letters' and staff were "the girls with the golden letters."

These two discourse streams ebbed and flowed throughout the case and the two competed for dominance of the overall hospital and especially within the Cashel group. For instance, the cycle of action to create a belief that the merger would happen strengthened the logic that the merger was both needed and was good for the hospital and the staff (the change agenda). The domination of the 'it won't happen' group ebbed and began to lose ground. The 'it won't happen' group subsequently extended the debate into an industrial relations conflict on the grounds that human resource issues were not being resolved, thus restarting the flow of 'it won't happen' and ebbing the tide for change. Similar patterns of competition for the dominant position are evident elsewhere. For instance, the



medical consultants threatened to withdraw their services because of the medical risks associated with the separated services. The result of the action would have been to effectively leave no medical cover in South Tipperary, closing both hospitals (Cashel needed medical cover for patients even if it was only a transfer arrangement). This again helped swing the dominant discourse to the change agenda. The interventions of the Cashel hospital action group and the compensation claims made by the Cashel unions were also tactics used to create legitimacy for the 'it won't happen' discourse. The interventions of the management, and particularly, the Hospital Manager also impacted on this ebb and flow of the dominant discourses. She systematically addressed each argument of the 'it won't happen' discourse and led the management team in bringing problem discourses into the open where they could be codified and resolved. Her interventions were also designed to ebb and flow the discourses, for instance the announcement by the HSE of the amalgamation date gave authority and permanency to the date of transfer, as did the involvement of the most senior IR teams within the HSE in the compensation negotiations. She lobbied, cajoled and coerced to maintain a change discussion as the major theme. The participative style helped bring forward the arguments and debate them. The openness provided the opportunity to challenge assumptions of both camps systematically and it served to reduce the currency of the 'it won't happen' argument.

Post-merger the two themes of discourse still existed. It is clear from the interview data that the same beliefs, that the merger has not improved the position of the hospital, that it was not the right time and Clonmel was not a

good place to work, still existed. Additionally, the post-merger questionnaire indicated that the Cashel cohort had lower average scores than other groups on all the assessment of the merger outcomes. This lower average arose because a significant percentage of the cohort consistently responded negatively to each question. These were however a small minority. The questionnaire data and the interviews clearly point to a conclusion that six months post-merger the dominant discourse was that the change was in the interest of the patients and that the hospital had to get on with their job and deliver the best services within the context of their resources. While the discourse of 'it won't happen' still existed its currency had dropped and its flow had ebbed. Given the existence of the discourse however this is not to say that it had been eliminated.

The flow and ebb of the discourses were directly related to the issues of boundaries. The differences that were identified formed a set of potential boundaries that could be used to differentiate the groups. For instance, the terms and conditions of employment for Cashel staff, including custom and practice, were different than Clonmel. Asking people to change to do on-call or different start times represented an opportunity to develop the 'it won't happen' discourse. A humorous example of this was the call from Cashel staff that they must continue to enjoy their free brown bread. This traditionally had been baked in the kitchen each morning and was made freely available to all staff. The management team costed this proposal and calculated that it would cost €30,000 p.a.<sup>72</sup> Only when it was put into these terms did the request become illegitimate. All the challenges to the transfer of services related to the set of boundaries.

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<sup>72</sup> This would be equivalent to the average industrial wage.



### 9.3 Theorizing Boundary Saliency

The experience in the hospital study allows us to develop theoretical insights on how boundaries become salient. While the hospitals appear to have merged successfully the divergent discourses, pro- and anti-change, continue to be present six months post-merger. The legitimacy of the two discourses however had changed radically, and the domination of a positive outlook on the merger was evident. However, differences between Cashel and Clonmel staff still existed and these still had the potential to create salient boundaries. Furthermore, these boundaries (i.e. on-call issues and changing areas) did differentiate the groups pre-merger, creating delays and resistance in the merger process. While we might have anticipated variations in perceived outcomes among staff pre and post-merger there still remains a major disconnect in that boundaries used to delay the process (i.e. the union withdrawal because the terms and conditions were not agreed) and their associated discourses remain post-merger but do not appear to create conflict or problems.

The theory of boundaries developed in the initial study makes a number of assumptions:

- Boundaries are the tangible and intangible facets of the social fabric of any organisation.
- Boundaries allow an organisation differentiate itself from others.
- All differences between groups provide the potential for boundaries.
- Boundaries exist in a latent state.

The hospital study extends these assumptions. The evidence suggests boundaries are a *dynamic* capacity for groups to differentiate themselves by actively managing boundaries in a legitimising process. This ties to the notions of social identity theory (SIT). That theory suggests that identity is managed by reference to in-group out-group processes. SIT suggest that groups will increase their social standing by selecting factors of difference that allow them increase their status by giving preference to certain factors over others, for example customer care over profit. These factors become salient because they can be meaningfully used to differentiate and allow value judgements (one group is better than another) to be supported. However, boundaries were used in a much more active manner in the hospital study. They were used to prevent merger progress by ‘*giving legitimacy*’ to being different groups rather than just assigning values to the difference. SIT takes the formation of groups as a given, Boundaries within the study were actively managed to create the group by highlighting differences that would separate the two merging hospitals and sustain the discourse of ‘it won’t happen.’ SIT considers salience as arising from identity accessibility and identity fit (see section 2.2.3). Drawing on this idea, the boundary types represent the potential boundaries that are available and accessible. Fit, however, which Hogg and Terry (2001) describe as matching an accessible category to the social context, was more complex. Boundaries were used to define the social context and maintain separation between the Cashel and Clonmel groups by matching contextual factors and perceived differences. For example, lack of funding for Cashel was related to terms and conditions of employment and used to trigger industrial relations procedures. From the data four strategies were evident in how the boundaries were made into salient differences by giving legitimacy to



group differences and these are summarised in Table 9.1. These strategies are independent of each other and can occur concurrently. The four strategies can be defined as:

1. **Creating group cohesion:** Establishing and enforcing group norms to create a common unified opinion and reduce the legitimacy of any within group dissent.
2. **Validation by the powerful:** Giving support to a position by formal and informal leaders to strengthen the discourse.
3. **Sustaining discourse:** Selecting differences to recognise boundaries that are relevant to the group and which can be legitimised as important dimensions of difference so that they are enduring and more difficult to resolve.
4. **External validation:** Using external constraints or bodies to escalate the importance of a particular boundary and extend the debate beyond the existing discussion forum by linking responsibility for action to others.

Table 9.1 Dimensions of Strategies for Supporting Separation

Table 9.1 Dimensions of Strategies for Supporting Separation				
Strategy	Definition of Strategy	Implementing Strategy	Impact of Strategy on Boundaries	Examples from Hospital Study
Group Cohesion	Establishing and enforcing group norms to create a common unified opinion and reduce the legitimacy of any within group dissent.	<ul style="list-style-type: none"><li>Provide repertoire of 'plausible' group beliefs that are not challengeable by group members (e.g. we are being mistreated or will lose, we are in this together, it is our union policy)</li></ul>	<ul style="list-style-type: none"><li>Heightens impact of a difference as staff must accept that differences exist and that they are problematic.</li><li>Unifies voice about the importance of a particular difference reducing options for solutions other than direct resolution</li><li>Reduces effectiveness of communications</li></ul>	<ul style="list-style-type: none"><li>Established repertoire of reasons why the hospitals cannot merge (e.g. seen all this before)</li><li>Sense of family and solidarity that existed in Cashel and sense of loss in breaking it up</li><li>The local union directives that created joint action from all nurses</li><li>Thoughts that the merger could be deferred indefinitely ("<i>we though we could hold it up again</i>")</li></ul>
Validation by the Powerful	Giving support to a position by formal and informal leaders to strengthen the discourse.	<ul style="list-style-type: none"><li>Control of communication channels</li><li>Information referent effect – greater weight given to own group interpretation</li><li>Keeping an issue at the forefront of discussion</li></ul>	<ul style="list-style-type: none"><li>Gives leadership to salience</li><li>Increases the strength and importance of differences</li></ul>	<ul style="list-style-type: none"><li>Lack of engagement of consultants – staff believed the merger could not happen until consultants agreed (e.g. too many issues not resolved)</li><li>Senior Cashel staff as opinion leaders and as a major source of staff information (e.g. Cashel not being resolved)</li><li>Senior staff generally were on transfer partnership teams</li></ul>
Sustainable Discourse	Selecting differences to recognise boundaries that are relevant to the group and which can be legitimised as important dimensions of difference so that they are enduring and more difficult to resolve	<ul style="list-style-type: none"><li>Discourse highlights particular boundaries as relevant over others (show people what differences exist)</li><li>Sense-giving to facilitate understanding in a complex context (tell people what is important and why it is important)</li><li>Personalise issues (create fear of changes)</li></ul>	<ul style="list-style-type: none"><li>Particular boundaries become more central than others and gain in importance</li><li>Places boundaries in context of values and beliefs of the group</li></ul>	<ul style="list-style-type: none"><li>Particular boundaries such as break-up of the 'family structure' given priority over other boundaries such as service provision</li><li>Strong focus on personal impacts in terms of on-call duty/ additional travel etc</li><li>Perceived mistreatment of Cashel specific issues during first AR cycle</li></ul>
External Validation	Using external constraints or bodies to escalate the importance of a particular boundary and extend the debate beyond the existing discussion for um by linking responsibility for action to others	<ul style="list-style-type: none"><li>Link boundary to presence of other external group and escalate the dispute to a more formal process</li></ul>	<ul style="list-style-type: none"><li>Shifts responsibility for boundary resolution to others (elongates and problematises the boundary)</li><li>Removes decision-making from group</li></ul>	<ul style="list-style-type: none"><li>Staffing issues in Cashel were linked to union s (e.g. union withdrawal from merger process)</li><li>Service levels were linked to Cashel Action Group (e.g. high court agreement)</li><li>Clinical issues were linked to Consultant Association</li><li>Compensation claim was linked to national IR agreements (e.g. final labour court recommendation)</li></ul>



### 9.3.1 *Creating Group Cohesion*

Group cohesion arises when a group share common understandings and have established norms of acceptable behaviour and values that serve to bind together the group in common action. Cashel showed strong unity at many stages in the merger. For instance in initiating industrial action or in defining themselves as a *family* that ‘*looked out for each other.*’ The ebb and flow of the “change” versus “it won’t happen” debate in Cashel was mediated to a large extent by this sense of group cohesion. The family atmosphere at Cashel tacitly obliged others to support them. While it became clear that two sub-groups existed in Cashel, one supporting and one rejecting the change, the cohesiveness of the overall group meant that it spoke with one voice and engaged the merger process as one entity. .Cashel succeeded for large parts of the amalgamation process in actively separating the hospital from STGH by enacting differences that were supported by the Cashel group collectively and cohesively. There were two sets of actions that created group cohesion:

1. maintaining a view that the merger could not happen without group consensus (i.e. maintain group norms given the ‘family’ atmosphere);
2. enforcing the sense of cohesion through informal and formal structures (i.e. must adhere to union guidelines and support colleagues).

There was strong evidence that the Cashel group had established local routines to support and enforce cohesion by providing an on-going repertoire of group beliefs that were plausible and internalised by the group. Since the announcement of the merger in 1995 a set of reasons why the merger could never

happen emerged. A repertoire of legitimising beliefs had been developed to justify the impossibility of the transfer including,

- critical issues could not be addressed;
- key people were opposed;
- it was a political decision and the politicians in Cashel would never let it happen. The local people would never allow it, the consultants were opposed and the problems within the hospital could never be resolved.

These were further supported by on-going resistance to the change evidenced in statements such as *the last three Christmas dinners have been our last* or *we never believed it would happen*. This underpinned a social discourse and belief that the merger would continue to be delayed. The consistent reinforcement of this message allowed the view to persist and become ingrained into the psyche of the hospital so much so that to question it would be inconceivable.

The level of cohesion that existed in Cashel was further evident in the results of the action cycle. The results suggested poor communication penetration and engagement had been achieved relative to those achieved in Clonmel. While many of the staff in Cashel engaged the change intervention, many others did not engage it. Similarly, while significant time and resources had gone into communicating with the Cashel staff and many opportunities had been given to staff to meet with management, it became evident that the messages had not been fully received or at least not fully accepted. Cashel's collective belief that the merger could not happen acted as a filter that reduced the effectiveness of the



communication by defining communication needs in terms of what would happen to Cashel post-merger (i.e. to the group) rather than what would happen as the combined STGH. Communication delivered by STGH management was therefore set-aside, even though it did address the communication needs of the majority of staff, because it failed to address what was seen as the collective concern. Credence was given to the argument that Cashel was being dismantled. What was promised in the high court agreement was not in place and the work terms and conditions for those with letters of comfort and who legitimately wished to stay in Cashel was not agreed. This phenomenon is well established in SIT as a group referent information influence (Haslem 2001). Broadly, information that comes from a referent group (Cashel in this instance) is more likely to be believed and its contents more likely to be engaged than a message arising from outside the group (van Kippenberg et al 1994). The first action cycle was a major learning experience for management (and for the research). The questionnaire administered at the end of this cycle indicated that Clonmel felt very well informed and Cashel felt very poorly informed<sup>73</sup>. Given that both had exactly the same communications the only difference could lie in the context of the hospitals. Cashel wanted information on what services would remain in Cashel and the impacts on them personally; they were less concerned with information on the broader amalgamation issues. Although in practice a substantial number of staff did not have letters of comfort and were motivated to make the transfer happen (as were many with letters of support), the cohesiveness of the group, meant that group norms required support to be given to the Cashel issue of what services would remain. This was further highlighted

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<sup>73</sup> This questionnaire had a poor response rate and can only be taken as indicative.

at the end of the first action cycle when the belief that the merger would in fact happen began to gain credence. Cashel reinforced cohesion by focusing on the Cashel hospital post-merger and on the unfairness of not knowing what was going to happen to the hospital post-amalgamation. The involvement of the union also acted as a cohesive force as staff members were unable to act counter to the official union position. This reinforced legitimacy of the 'it won't happen' group's position.

A strategy of group cohesion is therefore created when groups internalising a plausible set of group beliefs that alienate other views and which reinforces through group norms a dominant view that the group should act in unison against change. This strategy was build on a view that together the hospital's family culture could work to support the staff against being mistreated (sense of justice), becoming worse off in terms of employment contracts or become subsumed into the larger STGH. The ability to relate issues to all staff (even if they only affected some) through mechanisms such as union policy or through fear of not supporting colleagues (group behaviour norms) ensured group cohesion.

The impact of this strategy on boundaries is that it heightens the impact of a particular boundary because it becomes a unified group issue affecting all staff, even if in reality it only impacts on some of the staff. This was particularly evident in a number of boundary conflicts. For instance, the decision to implement industrial action over the non-funding of Cashel (only a small number of staff would be remaining) garnished full Cashel support and resulted in a substantial delay in the merger. Similarly, on-call duty became a major



contention for all staff notwithstanding that it only impacted on some individuals. In this way creating group cohesion provides a stronger voice about the importance of a particular issue and strengthens the negotiating position against the change increasing the relative importance of the boundary difference. As the strength of opposition grows the discretion management have to resolve the issue may be reduced. The more successful the cohesion strategy, the stronger the pressure on management to resolve the issue as the opposing group demand.

### *9.3.2 Validation by the Powerful*

A second process of creating legitimacy for the salience of a boundary was through the opinion leaders in the hospital. Leaders validate actions by giving weight to certain types of actions over others. Leaders often have the right of sanction (formal or informal) and the ability to exercise power in obtrusive and unobtrusive ways. In this respect the importance of the leaders in setting the context of the merger was visible. Many of the staff members with letters of comfort were more senior members of staff, both in the formal hierarchal sense and in terms of the informal sources of power such as stature. They were therefore in a stronger position to express the importance of a particular position and to achieve buy-in to it. It was the issues of staff remaining in Cashel that created significant problems and resulted in the withdrawal of staff from negotiations. It should be noted however that many of the leaders understood the importance of the amalgamation and actively worked toward achieving it.

The powerful validated the discourse of separation in a number of ways

1. Keeping their issues at the forefront of discussion through their control of communication and management channels;
2. their engagement (or lack of engagement) with particular issues;
3. their ability to directly interpret and filter communication to staff in a way that supported their view.

The issues that created substantial difficulties often related to the post-merger position in Cashel. These issues related to the letters of comfort held by the longer serving staff. The weight of their voice in keeping the issue at the forefront of discussions was evident. As more senior staff members, they attended the management meetings, acted on many of the integration partnership committees and were often, the conduits through which information flowed. Their experience and opinion was respected. Staff would listen strongly to them. And accordingly they held strong influence over how information might be interpreted consistently with their worldview. There were several statements of the type '[our leaders] have told us this will impact on us' Similarly, the surgeon's opinions were held in very high regard and some of their comments in terms of 'it wont happen until [this issue] is sorted' was often quoted as a reason the merger could not happen. There was a strong expectation, among staff and management that until the consultants agreed to transfer no merger could take place.

Similarly leadership direction was also evident in the visibleness of buy-in to the transfer. The surgeons, in particularly, did not engage the transfer process and



generally did not participate in the partnership groups. Staff could not picture the transfer occurring without their input. Surgeons controlled the workflow in the hospital through the clinic structure and their support for the move and the operational necessities to achieve it, for instance scaling down surgery for a period in anticipation of the move, was absolutely necessary for success. The merger could only be realised when these surgeons were fully supportive of the move. Their involvement became strong as failing equipment and facilities in Cashel (and the pending accreditation review) began to threaten the sustainability of the surgical services in Cashel.

The third example of validation by the powerful, ties back to group cohesion, and the ability of the more powerful staff to set the agenda for discussion and to provide interpretations of events that have greater strength of persuasion than other interpretations. Management statements and interactions with staff were in many cases channelled through the leaders and the formal communication interpreted through more informal conversation that occurred in the daily activities of the hospital. This is consistent with SIT discussed earlier. It is clear that the discussion in Cashel most frequently revolved about the unfair treatment of the Cashel group and the general loss of the Cashel family; these were issues of greater importance to staff with letters of comfort. It was notable that their ability to sustain this validation role weakened considerably once their issues were being addressed.

Validation by the powerful has a direct impact on boundaries. By maintaining a difference at the forefront of discussion, the powerful can provide leadership to

the salience of that difference enforcing both the existence and importance of the difference. Hence the Cashel staff took industrial action because of the lack of agreement on issues that substantively affected the more powerful group in the hospital. Leadership to the issue is given through active interpretation of events that keep the issue in focus and through active participation with or disengagement from selected issues to symbolically reinforce the boundary difference.

Powerful groups set the context of the merger by helping staff interpret the complex and uncertain events that were occurring. Staff looked to opinion leaders for cues about the merger. This allowed powerful groups, tacitly and deliberately, to influence outcomes. They led the discourse of separation, they supported industrial action and they discounted the change discourse. Only when the powerful groups (particularly the surgeons) supported the transfer did the amalgamation actually occur.

### *9.3.3 Creating a Sustaining Discourse*

A third process of creating legitimacy was the selection of appropriate boundary types as the focal point of the discussion so that it would allow a sustainable discourse. Sections 8.2.1 to 8.2.4 on boundaries in the hospital demonstrated a range of boundaries that presented potential to differentiate the hospitals. However, boundaries have different impacts in different domains of influence, for example the loss of the family atmosphere in Cashel is unlikely to create sympathy for the Cashel staff in external domains but be highly relevant in internal discussions. Not all boundaries therefore have the same impact on how a



particular group will see them. A strategy of maintaining separation can only be achieved if appropriate boundaries that are meaningful to the group can be highlighted and engaged (with some of the other strategies identified). This strategy was implemented in the hospital in a number of ways.

1. personalise issues so that they are of more concern to the individual (i.e. create fear or generate expectations);
2. interpret selected differences which are plausible within the context of the situation as important and significant (i.e. tell people what is important and why).

The boundaries that continued to separate the hospitals until the merger were all concerned with the treatment of staff in Cashel and the work environments that they experienced. In many ways this was creating a discourse of fear. The move would result in changes to work practices that would impact badly on individuals, on-call duties and additional travel and so on. There was also a discourse on staff receiving compensation for the move and a general feeling among Cashel staff that the HSE must provide compensation, otherwise staff should not move. What is most interesting however is considering the conversations that did not emerge. Most notable, is the issue of patient care and services. Some months after the amalgamation of STGH, a set of maternity hospitals in a large city planned to merge. Ultimately, on the day of the merger, a dispute arose over the service provision levels and the need for additional staffing. The hospital staff refused to transfer and the amalgamation was put on hold for a number of weeks as a result. Exactly the same problem emerged in South Tipperary, staffing levels were always going to be sub-optimum on

amalgamation day. This resulted in a number of beds not being opened. The issue however did not create any problems. At no stage in the study did these service levels become a contentious issue. When we consider the logic of the amalgamation that the services could not continue on two sites because of the clinical risk issues then the capacity to sustain a discourse about service levels is limited even though the issue is real.

Sustainable discourses were evident around issues of treatment of staff, both those remaining in Cashel (the structure of services they would provide there) and the changes in the treatment of staff transferring to Clonmel. The link between group cohesion and sustaining discourse is also evident in that many of the issues revolved around the fair treatment of the group as a whole (i.e. union action) and the need to retain the sense of family that existed. There were also examples of how the discourse when faltering was supported by external validation (see next section). For instance when the legitimacy of Cashel being broken-up as a result of the merger was accepted internally, the Hospital Action Committee engaged the debate externally.

Sustaining a discourse about particular boundaries has the effect of giving more weight to one boundary type over another. Particular boundaries therefore become more of the focal point of debate and gain greater importance over others. Within the hospital the treatment of staff and the changes in work practices gained greater weight than staffing levels because that boundary had more resonance with the concerns of staff. More debate about that boundary was therefore evident and more managerial time and effort was necessary in



addressing and resolving it. Much of the transfer team's time was taken up with a limited number of physical boundaries around terms and conditions of employment such as on-call, roster time and support structures. The extent of the conversations around these boundaries gives the need to resolve them huge significance. A second impact of this strategy on boundaries is that the selected boundaries became more linked to the values of the staff and their assessment of fairness and justice. For instance, changes in on-call responsibilities were conceived as impacting life-work balance. Similarly, changes in reporting structures were seen as impacting on levels of seniority.

Sustaining the discourse is a strategy of selecting legitimate causes that would be considered by protagonists as relevant and concentrating the debate on these boundaries to sustain the difference. By concentrating the discourse on particular boundaries the significance of those boundaries is increased in the minds of staff and management and the importance and legitimacy of resolving them is greater.

#### 9.3.4 *External Validation*

External validation is a process of escalating the boundary difference by involving other formal groups in the discussion. The principal example of this is the engagement of industrial relations processes. External validation shifts the boundary difference from an inter-group difference to a third party debate. There are two potential outcomes of this strategy, firstly it delays the resolution by lengthening the timeline of resolution and secondly, it may make the resolution potentially more problematic because of the involvement of third parties. The strategy can be implemented by:

1. legitimise the linking of a boundary issue to an external agency or body that has authority to intervene and act on behalf of some party (i.e. unions represented the staff, Consultant Association represented the surgeons and Cashel Action Group represented the patients)

There were three example of the use of this strategy in the hospital merger.

Firstly, the use of unions to justify a valid claim against management served on at least two occasions to hold up the merger. The first was at the end of cycle 1. The failure of the government to specify and fund the remaining services that would be developed in Cashel post-merger prompted nursing staff to engage the unions on the matter. The result was the withdrawal of all nursing staff from further discussions on the amalgamation. The invoking of industrial action required compliance from staff and gave strong legitimacy to the dispute. It created a complete blockage to the progress of the amalgamation. Even when the withdrawal was reversed due to the release of funding by central government, the union was in a position to give further legitimacy to delays through initiating a compensation claim for staff transferring and for inconvenience caused by the amalgamation. This claim was finally resolved by the State industrial relations bodies but only two weeks before the final amalgamation date. The threat of union action was a consistent threat leading up to the merger day.

The impact of engaging the union was that the issue became officially supported by all nurses<sup>74</sup> in the hospital. This demanded cohesion behind the issue from all nurses in Cashel. So for instance, when Cashel shifted toward the change

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<sup>74</sup> Interestingly the same union represented nurses in Clonmel who wanted the merger to occur.



discourse after the cycle 1 actions, union action forced staff back to the original status quo and there was no other legitimate choice for the nursing staff.

Similarly, the Cashel Action Group served as a validating mechanism for maintaining services in Cashel as were other lobby groups and politicians.

Indeed perhaps the most important restraining factor in the merger was the initial high-court agreement that was signed by the parties. That defined the exact terms of the transfer and afforded protection to staff and the community within Cashel.

This group threatened to give voice to a different discourse, that the people of Cashel were suffering. In the end management action, in delivering the exact terms of the high court agreement, and in promoting the benefits of the new arrangements to the people of Cashel negated the strength of the action group.

Finally, the surgeons attempted to use their representative association to escalate their dispute over the number of beds available for surgery. Their aim was to protect their bed numbers and maintain control over their wards. They would lose this in a full service hospital were emergencies could result in medical patients using surgical beds. The legitimacy of this argument however waned as the clinical risks associated with non-transfer were impossible for any group of medical practitioners to sustain.

The impact of this strategy on the boundaries was that it served to shift the responsibility for boundary differences to other groups both problematising the boundary and elongating the time needed to resolve it. The involvement of a third party effectively removed the decision making responsibility from the

protagonists and often prevented their continued engagement with the issue. For instance differences between Cashel and Clonmel became impossible to resolve once industrial action was taken. Furthermore, management decision-making ability is curtailed when external involvement occurs because management must subsequently adhere precisely to the terms of any external agreement. A clear example of this was the need to deliver the exact terms of the high-court agreement even though medical best-practice had advanced and changed since the agreement was made.

External validation is a strategy designed to support internal positions by referring problems to higher-authority external groups such as unions, pressure groups or professional associations. It limits the ability of internal parties to agree to or participate in agreement processes which can result in an elongated decision process or more problematic resolution pathway.

### 9.3.5 *'Voice'*

Having considered the processes by which boundaries became salient it is important to examine how those strategies were applied. The assumption that boundaries are actively manipulated to create salience for a particular purpose suggests that some 'voice' is represented by the desire to select and make a particular boundary salient. The four processes discussed above, however, are strategies for creating power and influence. In this respect they represent not so much the single voice of a dominant group but the struggle to exert influence and control by individuals or groups. The dominant position in the hospital represented the struggle between the 'change' discourse and the 'it won't



happen' discourse and the ebbs and flows of their interactions. Hence, at times the 'it won't happen' discourse dominated and controlled while at other times (for instance the final merger) the 'change discourse' dominated. This explanation for the voice in Cashel also explains the continued existence of the 'it won't happen' dialogue (now more 'it shouldn't have happened') in Clonmel post-merger. While the perception exists it has no way of being legitimised within the current environment because its position is weak (or has ebbed completely) and none of the four strategies identified above can be applied to it. The discourse now represents a small sub-group of a much bigger hospital that is now concerned with daily operations rather than going back to a completed merger. The powerful elite that existed in Cashel remained on that campus and the new leaders are focused on new challenges. Similarly, there is little chance of sustaining a dialogue on any issues that have an historic focus and there are no external ways of validating the position. How this voice emerges is not part of the research objectives within this research but would be an interesting avenue for future research.

#### **9.4 Reducing Boundary Salience**

As the various discourse ebbed and flowed, management acted in several ways to impact on the discourses. The adoption of the boundary framework allowed interventions to be targeted at the differences in boundaries and to homogenise those boundaries. In addition, however, the interventions had a secondary impact and one that only became evident as the tensions between the two discourses intensified. The actions of management directly contributed to the debate on the legitimacy of one discourse over another. In effect the interventions were often

designed (albeit unintentionally in some instances) to give authority (formally and structurally) to the change agenda and to reduce the authoritiveness of the other discourse. Reflecting on the actions post-merger, four separate strategies are identifiable from the actions taken (table 9.2) and these can be defined as follows:

1. **Resolving:** Directly identifying and resolving any perceived differences so as to eliminate the potential for the boundary to be defined as a boundary
2. **Pre-resolving:** Identifying and resolving potential perceived differences so as to eliminate the potential for the boundary to be defined as a boundary before it is recognised as a difference
3. **Isolating:** Publicly recognising a particular problem requires a specific process to resolve it and separating that issue from other issues so that its impact on other boundaries is minimised
4. **Repopulating:** Changing the staff profile to bring new ideas and practices into the organisation

#### *9.4.1 Resolving*

The simplest and most obvious strategy to deal with perceived differences is to resolve them by directly addressing the difference and aligning the boundaries to the satisfaction of the groups concerned. The study shows two ways through which this strategy was implemented.

1. Providing forums for problems to be discussed and resolved:
2. Communicating that the differences have been resolved.



Table 9.2 Dimensions of Strategies for Supporting Integration

Strategy	Definition of Strategy	Implementing Strategy	Impact of Strategy on Boundaries	Examples from Hospital Study
Resolving	Directly identifying and resolving any perceived differences so as to eliminate the potential for the boundary to be defined as a boundary	<ul style="list-style-type: none"><li>▪ Provide forum for problems to be discussed and resolved (e.g. groups and events)</li><li>▪ Communicating that the difference no longer exists</li></ul>	<ul style="list-style-type: none"><li>▪ Eliminates perceived difference and removes boundary as a source of difference</li></ul>	<ul style="list-style-type: none"><li>▪ Tasks groups established to address boundaries (e.g. the partnership committees that homogenised work-flows etc)</li><li>▪ Espoused strategy that management would resolve issue</li><li>▪ Availability of management team to meet and discuss any problems</li><li>▪ Communication strategy aimed at keeping all staff informed of progress</li></ul>
Pre-resolving	Identifying and resolving potential perceived differences so as to eliminate the potential for the boundary to be defined as a boundary before it is recognised as a difference	<ul style="list-style-type: none"><li>▪ Provide mechanisms for uncovering assumptions and pre-conceived ideas so that potential problem areas are resolved</li><li>▪ Leader interventions to recognise potential problem areas</li><li>▪ Takes leadership of the issue</li><li>▪ Define issues as resolved</li></ul>	<ul style="list-style-type: none"><li>▪ Removes boundary as a legitimate source of difference because it is already being addressed</li><li>▪ Avoids the ability of others to take a leadership position on an issue</li><li>▪ Pre-empts any problems with boundary difference by resolving it first</li></ul>	<ul style="list-style-type: none"><li>▪ Integration days created dialogue about futures</li><li>▪ The development and publishing of a common mission statement</li><li>▪ The dialogue within hospitals on values codified similarities</li><li>▪ The decision to continue with the accreditation process drove commonality on processes</li><li>▪ Establishing the amalgamation date from the central management structure to avoid debates on whether that date was appropriate</li></ul>
Isolating	Publicly recognising a particular problem requires a specific process to resolve it and separating that issue from other issues so that its impact on other boundaries is minimised	<ul style="list-style-type: none"><li>▪ Provide a process through which the legitimacy of a claim is recognised and which can be used as a mechanism for resolving the problem without impacting on other issues</li><li>▪ Separate boundary issues from one another</li></ul>	<ul style="list-style-type: none"><li>▪ Diminishes the impact of a particular boundary on others</li><li>▪ Removes the boundary as a legitimate source of difference because there exists a process to deal with the difference</li></ul>	<ul style="list-style-type: none"><li>▪ The creation of a dedicated partnership group for Cashel</li><li>▪ Agreeing compensation issues must be dealt with via the Labour Relations Commission but on condition that other activities were not stopped</li><li>▪ The high court agreement</li></ul>
Re-populating	Changing the staff profile to bring new ideas and practices into the organisation	<ul style="list-style-type: none"><li>▪ Recruitment and promotion from external sources</li><li>▪ Use of external experts or change agents</li><li>▪ Adoption of best practice based on external perspectives</li></ul>	<ul style="list-style-type: none"><li>▪ Weakens links and group identity toward old ways so that boundary difference are less important</li><li>▪ Creates impetus for new boundary configurations that transcends existing boundary differences</li></ul>	<ul style="list-style-type: none"><li>▪ Recruitment of new staff at merger date</li><li>▪ Change in name to STGH at earliest point and the creation of a STGH contract</li><li>▪ Use of best practice models such as accreditation to change structures and processes</li><li>▪ Use of AR as a means of externalising the change</li></ul>

From early in the amalgamation process the management team worked hard to identify the issues that would hold up the amalgamation in an effort to reduce the potential for the 'hospital within a hospital' to develop. They set about defining the issues of concern to both hospitals. They did this by conducting interviews with staff and from creating forums for issues to be raised, such as integration days and meetings with the Hospital Manager. Furthermore the partnership structures that the hospital developed provided a clear mechanism for issues to be raised and addressed. Every aspect of the amalgamation was considered and common work-pathways and procedures were developed. Similarly, the accreditation process was used as a direct means of resolving problems that had been identified. Throughout the process hospital wide groups took on boundary issues and attempted to resolve them. This dealt with the issues and served to enhance the perception that the post-merger position of the hospitals would be capable of delivering improved patient care and services. It also served to reduce the uncertainty levels as a clear and visible process to resolve issues was evident and widely communicated. The 'it won't happen' discourse lost legitimacy either through the resolution of issues or assignment of it to a working group. The working group structure gave authority to those influenced by the change to design that change and in this way gave control of the change to those influenced by it. This reduced the capacity for the 'it won't happen' discourse to justify continued separation on any of these grounds as the resolution or opportunity to resolve them existed.

The hospital also communicated widely when issues were being resolved, for instance the monthly newsletter reported on amalgamation progress and featured examples of how the two hospitals were working to resolve issues. The



partnership structure also served as a communication channel with reports being fed back to staff through management and departmental meetings as well as through informal contacts.

The impact of this strategy on the potential for boundaries to become salient is obvious. The attempt to resolve differences acknowledges the existence of the difference and provides a commitment to its resolution. By being able to define the resolution or even the path to resolution, the currency of the difference as a potential to maintain separation is reduced or eliminated. This impact was evident in many ways in the hospital study, for instance the accreditation process addressed work procedures and homogenised processes and prevented work process related boundaries emerging post merger. Similarly allocating car parking spaces, or agreeing to work practice changes reduced the potential for a conflict to arise.

Of course, not all issues could be resolved, and some were outside the control of management (and it was these that were the cause of industrial relations actions). Furthermore, although it did not happen in this case it may not be desirable or acceptable for a particular issue to be resolved, for example pay issues. The hospital study had a number of issues outside of the control of management, notably the compensation claim, the services to remain in Cashel and other funding issues. Additionally, there were latent boundaries, such as beliefs, that had not been raised as an issue and therefore could not be directly addressed. This strategy of resolution cannot therefore be applied in all cases.

### 9.4.2 *Pre-resolving*

A pre-resolving strategy is designed to prevent a potential boundary becoming salient before the boundary has the opportunity to create difficulties. In effect a pre-resolving strategy addresses the boundary difference between groups prior to the groups recognising that the difference is relevant. A pre-resolving strategy will seek to:

1. Surface assumptions and pre-conceived ideas about each group so that groups understand each others perspectives concerning future potential problems;
2. Provide leadership and direction to issues so that they are addressed by appropriate interventions;
3. Define issues as resolved.

There are a number of examples of how these strategies were implemented within the hospital. Firstly, there were several forums that allowed future issues to be identified and for interventions to be made prior to any conflict arising around the issue, particularly the integration days and indeed the wider participative integration team structure. A good example of how the strategy surfaced assumptions and understandings arises from the integration days which spent considerable time discussing what would happen on the day of amalgamation and what management and staff should do. The ideas of celebrating the day and of having a welcoming party arose from this forum as did the clear recognition that routine issues, such as car parking access needed to be clearly defined for the day. That forum also allowed staff from all groups to discuss in an open way the issues they felt were important to them. This helped building understanding between groups especially in terms of the traumatic



changes that the Cashel group were undergoing. This understanding was clearly evident in the sympathetic understanding of the Cashel position among Clonmel staff. For instance the previous chapter (chapter 8) showed how Clonmel staff expressed concern about Cashel's loss of identity, loss of bed spaces and the break-up of their team.

Secondly, there were examples of how leadership was given to particular issues. A particular good example of this leadership was the development of the mission statement. The mission statement development process established a dialogue on the values and beliefs of both hospitals and directly addressed cognitive boundaries prior to any debate on differences emerging or indeed any contact around values actually occurring. The development process was focused on creating a common agreed mission statement underpinned by research and dialogue in each hospital. While the discussion did not take place in a common forum, the research conducted did create a common agreement about what should be included in the statement and what was the key values of the combined hospital. Codifying the dialogue in each hospital facilitated the linking of common values and beliefs and helped to uncover and express similarities which directly removed the opportunity for boundaries based around values to emerge. By achieving a high level of agreement on core values the hospital management were able to state with authority that the hospitals shared common value systems and were able to define the culture of the hospitals as the same. The mission statement was highly publicised with management-staff meetings occurring in each hospital and with several articles over a protracted period of time being published in the staff newsletter. The accreditation process had a similar pre-

resolving effect. Many of the issues that were related to the amalgamation of services, such as common patient pathways or common quality procedures, became part of the accreditation process and were resolved in that process. This prevented staff from linking them to the amalgamation as they were or had been resolved in a different forum.

Finally, another dimension to pre-resolving boundaries is giving legitimacy to a particular issue in a way that constrains the ability of others to debate the issues. The best example of this is the setting of the amalgamation date. The hospital management set amalgamation dates on two occasions but could not deliver on these dates. However the final date was established by reference to a higher authority level – the HSE’s CEO. In so doing the date as a means of discussing boundary differences (i.e. cannot merge on that date because something is not done) was eliminated as staff had to work to the defined date and the hospital management themselves had no discretion. This action allowed management to create a pre-defined response (it has to be that date) to the very vocal campaign that the lead time was *‘too short’* or that it was *‘the wrong time of the year’*.

The impact of the pre-resolving strategy on the potential for boundaries to become salient is that it reduces the potential by removing the boundary as a potential source of difference because it has been resolved and therefore, in its ultimately successful state, no difference exists. This was evident in the values and mission of the hospitals. A second aspect of the pre-resolving strategy is that the strategy also provides an opportunity to take ownership and leadership on a particular issue. For instance the management intervention on values allowed the



management to lead the development of the mission statement proactively and to avoid any debate on the potential difference because of that leadership. While it did not occur in the case, management would be well position to rebuke any dialogue that substantial cognitive boundaries existed within the study. This could be rebuked on two grounds, firstly that the evidence to debate that issue was been collected and that the debate was not legitimate until that evidence was collected and secondly, that if differences did exist then it could be addressed through the groups that had been established. Pre-resolving issues removes the capacity of any group to use the issue to legitimise that a boundary operates around an issue. Furthermore, it gives management the capacity to help socially construct a common agreed reality.

#### *9.4.3 Isolating*

An isolating strategy is aimed at separating a particularly problematic issue from other issues and creating a specific process for attempting to resolve that issue. By recognising the special needs of a particular problem, the strategy acknowledges the problem exists and attempts to build trust in a process to resolve it. This strategy is particularly relevant when the problem being resolved is beyond the normal capacity or remit of existing resolution mechanisms. For instance, it is not possible for the management to sanction a resolution because of resource or legislative conditions. These exact circumstances existed in the hospital case, the resolution of the Cashel problem, what would remain post merger in Cashel and how it would be funded, was largely outside of the control of the STGH management, dependent on state funding and on agreement among

several political stakeholders. The hospital did implement a strategy to recognise the problem and isolate it from other boundary issues. This entailed:

1. Recognising that the problem existed and that it requires a special task force or group to work toward a resolution;
2. Isolating the particular issue by de-coupling the problem from other boundary issues.

The principal mechanism through which this strategy was employed was the creation of a Cashel partnership group consisting of staff that might remain in Cashel. This new group was given the responsibility of planning for post-merger Cashel. This action separated the Cashel staff by creating two distinct groups, divided along the 'change' and 'it won't happen' discourses. Isolating the latter into one group concentrated and focused the discourse within the group and reduced the ability of the group to gain legitimacy for the 'it won't change' discourse within the wider hospital. The two groups could operate in separation and this reduced the frequency and impact of across group conversation. One group concentrated on Cashel post-merger and one group concentrated on the STGH amalgamation. It, accordingly, reduced the impact of the 'it won't change' discourse on the change agenda. The Cashel groups could pursue their individual discourses in isolation and both were validated and acknowledged but both were also separated. Other less dramatic examples of isolating issues are also evident in the study. For instance, the issue of compensation claims for the transfer was referred to the labour relations commission for resolution. It was agreed that the recommendation of the commission would be implemented and that while the resolution process was on-going the staff would continue to work on the amalgamation process and prepare to transfer on the agreed date. In this



way the boundary was isolated from others through it being recognised as important and through the creation of a separate resolution mechanism. Similarly, while outside of the particular remit of the management (and strictly speaking the boundary management approach) the high court agreement of 1996 was a strategy of isolating. It resolved a particular aspect of the amalgamation process by codifying and defining future actions around an agreed process, removing the ability of that issue to resist the change agenda.

An isolating strategy impacts on the potential for boundaries to become salient by recognising the problem and acting to resolve it. When a boundary difference is recognised it removes the ability of the group to argue that the boundary conflict is problematic because it is being addressed. This strategy is particularly important when the capacity to resolve the conflict is largely out of the control of management. In STGH there had been a realisation that the staff in Cashel had limited voice in determining the outcomes they would face, i.e. what would happen when they were left behind. Most of the attention was on Clonmel post-merger and the situation was exacerbated by the fact that reporting lines would change within Cashel post-merger with the existing hospital management having no inputs into the new Cashel set-up. Establishing the Cashel partnership group and bringing their new reporting line managers into that group gave some planning and authority to the Cashel group.

An isolating strategy is effective when significant boundary problems exist that can not be readily addressed. It allows the problem to be distanced from other issues. Of course, the resolution of the problem still remains an issue and the

structures created must create the potential for a resolution otherwise the conflict will re-occur. The hospital study successfully managed to resolve the outstanding issues so the study cannot speak to what would occur if this strategy failed to produce results.

#### *9.4.4 Repopulating*

Repopulating is aimed at creating change through the infusing of new people, processes or ideas into the merging organisations so that existing boundaries are exposed to additional differences beyond the current inter-group experience. By adding new experiences into the organisation the importance of existing inter-group differences is reduced in two ways. Firstly, the existing differences are challenged because new differences emerge and secondly, a third group is created which does not identify with either side of the existing inter-group differences thus weakening the importance of those differences. A repopulation strategy can be implemented through:

1. Bringing in new staff through external recruitment;
2. The use of experts and change agents to challenge existing views;
3. Adoption of best-practice models external to the existing organisation.

These three activities were evident in the study. Staffing changes arose out of necessity as well as design. Nurse staffing levels post-merger were projected to be severely lower than operational needs. This occurred for a number of reasons, from skill shortages in certain fields because of staff not transferring from Cashel, to increases in staff on maternity leave and increases in sick leave. The net impact of the shortage was a dire need to bring new staff into STGH. New



nurses were recruited through transfers from other hospitals and from temporary agency staff. In this way a significant repopulation of some parts of the hospital nursing staff occurred. The impact of this repopulation was that any 'us versus them' discourse was substantially ameliorated by a large number of new staff who could not identify with either 'us' or 'them' but rather described themselves as nurses. Secondly, the Hospital Manager from early in the amalgamation process recognised the need to challenge existing processes and wished to build an improved operating and cultural system within the organisation. The development of an action research process was a part of this philosophy and my role within the hospital was clearly one of change agent designed to stimulate discussions on new ways of thinking about the change. The third example of repopulation links to this point. The operation of the accreditation process and a significant part of all the team-work structures that the hospital developed was concerned with developing best-practice. The hospital throughout the merger process totally redesigned most of its operating and clinical systems and moved to new organisational arrangements (i.e. clinical directorates). This move to best-practice served to repopulate and rejuvenate the organisation in terms of processes and ideas.

The impact of a repopulating strategy on boundaries is that it reduces salience because it weakens the link between existing group boundaries and new organisational realities. By creating new systems and new ideas the existing processes are transcended and staff can jointly identify with newness rather than existing group boundaries. Similarly, bringing new staff into the organisation weakens the strength of group identity because existing loyalties are replaced by

new staff. In these ways repopulation creates the conditions and impetus for new boundary configurations.

Repopulating is an appropriate strategy when the aim is to create new organisational configurations (in people, process or structures) that transcend existing boundary differences. It challenges the assumptions that one group's perspective is better than another because it mediates that debate by bringing forward an additional legitimate alternative while simultaneously providing new voices in support of change. Furthermore, grounding the changes in principles of best-practice shifts the debate from the relativity of existing group perceptions to an externally valid benchmark reducing the potential for either group to argue against it. This was particularly useful in the hospital because the best-practice model was an obligatory quality framework that the hospital staff had to adopt.

## **9.5 Conclusion**

This chapter tracks the tensions that emerged between the pro- and anti-merger groups and shows how the discourse of the hospital translated potential boundaries into salient differences that either held-up or progressed the merger. The chapter answers the question from the third pillar of the research design by exploring how boundary salience occurs and how boundaries are changed. Identifiable strategies are uncovered that groups used to legitimise separation or integration respectively by creating meaningful contexts to support boundary formation. Strategies driving integration include:

1. Resolving; Establishing and enforcing group norms to create a common unified opinion and reduce the legitimacy of any within group dissent.



2. Pre-resolving; Giving support to a position by formal and informal leaders to strengthen the discourse.
3. Sustaining discourse: Selecting differences to recognise boundaries that are relevant to the group and which can be legitimised as important dimensions of difference so that they are enduring and more difficult to resolve.
4. External validation: Using external constraints or bodies to escalate the importance of a particular boundary and extend the debate beyond the existing discussion forum by linking responsibility for action to others.

While strategies supporting separation include:

- a. Creating group cohesion; Directly identifying and resolving any perceived differences so as to eliminate the potential for the boundary to be defined as a boundary
- b. Pre-resolving: Identifying and resolving potential perceived differences so as to eliminate the potential for the boundary to be defined as a boundary before it is recognised as a difference
- c. Isolating: Publicly recognising a particular problem requires a specific process to resolve it and separating that issue from other issues so that its impact of other boundaries is minimised
- d. Repopulating: Changing the staff profile to bring new ideas and practices into the organisation

The chapter argues that boundary salience occurs from the interaction of these strategies and the dynamic capacity to create meaningful groups that facilitate

separation. The engagement of the two sets of strategies created a political arena in which the set of discourses for and against change competed for domination. The next chapter will bring together the three pillars of the research design and expand the discussions to date to address the main research question, how boundaries are changed in an M&A, and translate the findings for the research into a usable set of theoretical statements with implications for theory and practice.



## **10 Discussion: Bringing the three pillars together**

### **10.1 Introduction**

The thesis has drawn on three strands of theory development, existing theory (to build on existing knowledge), fieldwork (to develop theory by explaining practice) and practice (to develop theory in practice) to explore and build theoretical insights on boundaries. This chapter will integrate the three strands of the thesis to inform the management of boundaries in an M&A and to develop five theoretical insights to help explain and manage boundaries.

The chapter further extends the understanding of boundary salience by examining how the strategies for driving integration and differentiation interact with both boundaries and management interventions. The chapter argues that two interrelated cycles exist, one concerned with managing the interventions to promote boundary homogeneity and the other concerned with creating a meaningful context for change. These two cycles must be managed if boundary conflicts are to be avoided.

At the outset of the thesis the contributions required from this work were laid out. The chapter delivers on these contributions and indeed goes beyond them. Five theoretical insights into boundary management are developed which explain:

1. how boundary salience occurs;
2. what strategies can influence salience of boundaries;
3. how boundaries can be classified;

4. how management interventions influence boundaries;
5. how the level of integration achieved is impacted by the strategies adopted and the management interventions.

Taken together these five insights represent a framework that explains how management can attempt to change boundaries during a merger and a six-stage practitioner guide is presented to translate the theoretical insights into practice.

## **10.2 Achieving successful outcomes**

The cornerstone of action orientated methodologies is to achieve successful outcomes in practical terms. Chapter 2 defined success as the achievement of stated objectives. The clearly stated objective of the hospital management in the amalgamation of services was to avoid a 'hospital within a hospital' arising post-merger, as had happened in previous hospital mergers. Their aim was to create a unified and well integrated hospital. Merger results suggest that the staff identified with the new hospital post-merger and that staff perceptions considered the hospital amalgamation successful. Moreover, management reflections suggested that the hospital was unified and that their fear of the hospital within the hospital had not transpired. The objectives of the hospital management were therefore delivered and the hospital merger was successful.



Table 10.1: Contribution of research phases to the development of theory

Understanding how we can change boundaries during an M&A integration to improve the potential for success			
	<b>Pillar 1</b> <b>Building Theory from Theory</b> (Chapter 2)	<b>Pillar 2</b> <b>Building Theory from the Field</b> (Chapters 5 & 6)	<b>Pillar 3</b> <b>Building Theory from Practice</b> (Chapters 6, 7 & 8)
<b>Research question(s) addressed</b>	What are boundaries, how can they be conceived and what actions (interventions) can impact on boundaries	What boundaries may exist in an M&A and how do the interventions impact on them	How do boundaries become salient and how can we use boundary theory to change boundaries
<b>Why is the pillar needed</b>	Develops an understanding of a new area of study. Boundaries in M&A are unexplored	Translates the boundary understanding developed in theory to the M&A context by extending it through fieldwork	Engages the theory in solving a practical problem to develop theory <i>in</i> practice and to explore how boundaries operate
<b>Contribution</b>	Boundaries defined as difference emerging from physical behavioural and cognitive aspects of social interaction. Boundaries are arbitrary and located as part of social interaction. Interventions to impact boundaries include, contact and awareness building, training and behaviour supports, and building vision	Identifies boundaries that emerge from the categories proposed in pillar 1. Relates interventions to impacts on boundaries Each boundary category creates a different tension for individuals and groups within the merger Each intervention impacts on boundaries in distinctive ways Relationship between intervention and boundary proposed	Confirms findings from Pillar 2. Proposes how boundary salience occurs and is managed. Uncovers strategies used to support and resist boundary change

### 10.3 Boundary Management in M&A Integration

This thesis has developed theory from three main pillars as outlined in Chapter 1. Each of these pillars has contributed to a deeper understanding of boundaries in M&A integration. Table 10.1 sets out the main contributions for each pillar.

The findings from these three pillars allow a number of theoretical statements to be made about boundary management in M&As and facilitates the development of a framework for assisting managers to change boundaries. The theory is based on the triangulation of all three sources of data.

#### *10.3.1 Theoretical Insight 1: Boundary salience occurs through a dynamic political process*

A boundary becomes salient when it is activated as a means of differentiating and separating groups. The hospital study demonstrated that at different times differences served to separate and bound the two hospitals (e.g. location, terms of employment etc). The importance of these differences ebbed and flowed throughout the study, moving between conflict and resolution. At times, the force for differentiation and separate boundaries was strongly legitimized and the groups enacted difference and separation, such as when the Cashel group declared an industrial dispute and withdrew from the amalgamation process. In contrast, the force for changing boundaries and uniting also dominated the discourse from time to time (for example the clinical risk associated with separation). The ebbing and flowing drew on physical, behavioural and cognitive



dimension of the organisation often in an arbitrary manner to select potential boundaries that could be used to support a particular position. Similar to Cohen et al's (1972) garbage-can model of decision making, coalitions sought out ways to legitimize their positions by selecting appropriate boundaries from those that were available to justify their position. Hence, issues like on-call duty and space allocation became problematic because they were seen as feared changes in the new hospital structures, while other issues like staffing levels (this halted another merger in the health sector) were largely ignored as a basis of action. While the financial services study does not have the same strength of data on boundary salience (it was not an objective of the data collection), some similarities with the hospital study are evident. In the more successful branch mergers the managers often created legitimate reasons why unified boundaries were required, for example through the designation of head office as a common enemy that had to be overcome. In less integrated branches a greater weight was often put on internal differences and greater conflict existed over the 'right way' to do business. Less integrated branches had much more disagreement on the value of the merger and discourses questioning the merger had stronger weight. This is very similar to the debates in the hospital study. However, it is also worth recognising that the hospital study represents an extreme case of merger integration difficulties. In the hospital the staff had more say in terms of whether the merger would happen, because the hospital was strongly unionized and because external factors (the letters of comfort) gave a level of control to staff. The study represents an extreme case of building up to a merger, taking twelve years to realize. The situation was accordingly more politicized. In this regard the hospital study offers a unique insight into the phenomenon.

The finding that boundary salience occurs through a dynamic political process of meaning creation is supported by theoretical insights arising outside of the M&A field. Political views of organisation have always emphasised the role of dominant coalitions and the fight for meaning creation as an exercise of power (Pfeffer 1981). Similarly, boundaries have been shown to be arbitrary in nature and socially enacted (Ashford et al 2000) mental fences (Zerubavel 1991) created by individuals. Multiple functions of boundaries, as interfaces (contact and learning about each other through the meaning creation process) and as perimeters and protection (justifying separation based on differences) are also evident in the process that creates boundary salience. Furthermore, social identity theory suggests that individuals are motivated to seek out differentiating facets of social groups as a means of managing status differentials and improving self-image. More directly in the M&A field, acculturation theory has been used to show how political interaction between merging units can build awareness and coalitions that support new boundary formation.

These theoretical insights strongly support the interpretation of the case data but it is worth noting, however, that the process uncovered in the hospital study differs from these theoretical models in one important way. Drawing from the work of Miles and Snow (1990) these models could be considered in terms of 'fit,' the alignment of strategy, structure and processes. Miles and Snow point out that fit is not a static concept but rather a dynamic process. Organisations strive to achieve fit through a continual process of alignment and realignment consistent with political views of change. This notion of fit is consistent with the assumption that all systems stand in a constant state of dynamic equilibrium:



constant forces for change and for stability converge to create a steady state. In this way, political views, social identity theory and the emerging boundary literature conceive meaning creation as a fight for hegemony between distinct perspectives. In contrast the fight for meaning creation within the hospital was motivated not just by the desire to create hegemony for one group's preferred ways but also a fight to justify continued separation and self-survival (as defined by the group). The dynamic search for difference was motivated partly by the desire to present an alternative fit rather than to determine the nature of the strategy, structure and process alignment. While the data exploration does not allow an assessment of the strength of this motivation, it is very clearly evident within the actions taken (e.g. strikes) by some staff. Nahavandi and Malekzadeh's (1988) exploration of acculturation suggests that when the culture of the acquired company is strongly valued by the staff and that the culture of the acquiring is not valued then the preferred mode of integration of the acquired will be separation. While this possibly explains why in some cases a group may not wish to merge with another, this was not evident in the hospital study. The two organisations reported very similar cultural values and shared senior management giving them consistent management philosophies. The dynamic process of finding boundaries to be salient was therefore a wider process than evidenced elsewhere in the literature.

10.3.2 *Theoretical Insight 2: Strategies exist to legitimise and de-legitimise boundary salience in an M&A integration*

The data shows a number of strategies that were used in the study to legitimize and to de-legitimize boundary salience. Two separate and distinctive sets of strategies were applied. One set served to support boundary integration and one set served to support boundary differentiation. These strategies are the techniques through which the battle for legitimacy played out in the study. Table 10.2 lists the strategies identified.

Table 10.2 Strategies used to legitimise and de-legitimise boundary salience

Strategies supporting boundary integration	Strategies supporting boundary differentiation
Resolving the issues	Creating group cohesion (a belief against change)
Pre-resolving issues before they become problematic	Validation by opinion leaders (giving powerful support to the case)
Isolating problems and containing them	Sustaining the discourse (highlighting boundaries to support case)
Repopulating groups to reduce strength of existing dogma	External validation (shifting resistance to additional levels)

10.3.2.1 Strategies Supporting Boundary Differentiation

The strategies legitimizing boundary salience supported boundary differentiation. Broadly, they created social structures that either bound the group together through established beliefs (group cohesion), reinforcement (validation) or creating new fears either through internal dialogue (sustaining a discourse of separation) or from external groups such as unions (external validation). These strategies often operated as an interlocking set of activities reinforcing one another. Uncovering this set of strategies is an important element of this work as



it identifies boundary forming activities and allows predictions to suggest how groups might act. Groups motivated to maintain separation will attempt to establish and maintain a dominant ideology by legitimizing particular boundaries. These boundaries will be based on a political choice model, with selection based on the ability to prove the strongest support to the dominant ideology. There is a resonance of this phenomenon with social identity theory and the motivation of people to select differentiating factors between groups in order to creating a meaningful self-image. Tajfel and Turner (1986) suggest that individuals are motivated to select criteria that allow them value their group over others, for instance in the financial services study groups polarized on the basis of customer service versus target achievement, with each group feeling the other did not understand the new context of the organisation. In this way each group created a positive self-image at the expense of the other, through the selection of an appropriate difference that gave value to their ideology. Similarly, social identity theory suggests that information flows from within the group are likely to have greater weight than those emulating from without. The strategies identified here provide an additional dimension to that view, not alone was there greater impact from communications emerging from within (for example the poor communication penetration achieved in Cashel cycle 1 of the hospital study) but strategies were targeted at enhancing the value of internal communications over external. The social structure had established an embedded discourse that the merger could not happen, any questioning of this assumption could be immediately challenged with a myriad of pre-established dogma as to why it would not happen. The closely knit nature of the 'family' environment further served to drive unity and consistency. Even when the internal structures

began to breakdown attempts to reinstate control by engaging strong external parties (the unions or political interest groups) to shore up the dogma occurred. It should be noted however that the hospital study represents a unique case of pre-merger process given the length of time it took to affect the merger. In that respect a large part of the history of the hospital involved the resistance of the merger and building dogma and defence routines to oppose it. The extreme nature of this case may have influenced the predominance and strength of the strategies.

Another aspect to the strategies used to sustain differentiation is the extent to which they were consciously developed. The data do not explicitly address this issue but they do shed some understanding on whether boundary salience emerges consciously from a motivation to maintain separation or from the social reproduction of the structure and culture of the organisation. The hospital study has examples of social reproduction particularly in the cultural values (i.e. family and size) embedded in the hospital. These served to create cohesion around the anti-change agenda. The study however commenced several years after the creation of these structures so it cannot speak to whether or not they were deliberately and consciously created. The financial services study in contrast had less embedded resistance to the merging of the branches but in conditions where lower levels of integration were achieved they did demonstrate a reluctance of staff to 'let go' of their original routines and culture. This is consistent with the M&A literature on stress and uncertainty in M&As (Marks and Mirvis, 1997a, 1997b,). Uncertainty and stress lead individuals to seek certainty in the 'known'; the routines and structures that have served them well and with which they are



comfortable. Individuals may therefore return to original routines and reproduce them as a means of reasserting control and certainty. This is evident in the hospital study as staff concentrated on the daily imperatives of running a hospital. Interestingly, it might be argued that without the belief that the hospital would continue, the very processes of maintaining and building service provision in Cashel could have become problematic. The need to keep patient care ongoing and to respond to the immediate needs of the work-flow may have necessitated the belief that the merger could never happen. For these reasons the identification of strategies to foster differentiation may be either consciously enacted or structurally reproduced. Clearly the question of who initiates strategy is a potential fertile ground for future research.

#### 10.3.2.2 Strategies Supporting Boundary Integration

Strategies designed to foster integration stemmed from the realisation that boundary differences had to be resolved if integration was to be achieved. The strategies were not initially developed as a distinct set of boundary salience interventions but rather emerged as the events of the merger unfolded and intervention outcomes became clear. The four strategies identified in table 10.2 represent a significant contribution to understanding how managers might act to reduce the salience of differences in a merger. All of the strategies involve reducing perceived differences. The easiest way of reducing a perceived difference is to align the two perceptions (resolving). This is of itself an intuitive finding as well as an empirical finding. It was done in many ways in the hospital, (for example, empowering the staff to resolve issues, training, pre-merger discussion days) and in the financial services study where branches that tended to

have better integration outcomes had managers that tackled issues head-on. At its simplest this strategy involves directly identifying and addressing boundary conflicts by dealing with them openly as they arise. Coupled strongly to this strategy are processes that are designed to uncover potential differences and to design actions to align them before they become problematic (pre-resolving).<sup>75</sup> This was quite evident in the partnership groups in the hospital study and the pre-merger integration work-streams that were used in the financial services study. The M&A literature, while not addressing the issues of pre-resolving, has emphasised the importance of organisations building pre-merger understanding (Haspeslagh and Jemison, 1991). The third strategy adopted was to isolate problem issues and to separate those issues from the wider context of the merger. This strategy emerged out of a realisation that the Cashel hospital consisted of multiple groups and that interactions with the group as a whole were less productive than interacting with separate and distinctive groups. The multiple group approach facilitated more directed communication and by addressing their unique problems more directly (the resolving strategy) their control over the broader group was diminished. Within the study the group that became separated consisted of a number of opinion leaders and by recognizing their claims, their voice within the wider discourse of the hospital lessened. This is a related but slightly different strategy to the resolving strategy. Here there are two processes at stake, the resolving strategy and secondly a disaggregating of different groups' claims that differences exist. Dealing with them separately (and particularly isolating problematic claims) lessens the impact of one on the other. Perhaps a similar phenomenon is evidenced in survivor syndrome (Marks and Mirvis,

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<sup>75</sup> Arising from the application of the boundary model.



1992, Brocknar, 1992), were feelings of guilt, stress and a sense of disconnection can often occur among staff that remain after colleagues have been made redundant. The assessment by staff about how fairly others are treated will directly impact on their actions. Hubbard (2001) also supports this position by linking work group concerns and organisational justice to merger outcomes. She suggests that where justice is seen to prevail greater engagement will be evident. Reducing the boundary salience for the remaining Cashel group and providing them with the necessary tools to design their new work environment served to bound that group from the wider community and allow management to resolve the group's concerns in isolation of the wider debate. The final strategy, repopulation, was consciously adopted as a means of renewing the whole organisation. By bringing new staff into the organisation, new work practices and cultural awareness would be fostered. In addition any boundary divide would be harder to sustain if new organisational members supported an external best practice model and could not identify with either of the existing groups.

### *10.3.3 Theoretical Insight 3: A theory of boundaries can classify boundaries as physical, behavioural and cognitive*

The thesis has cumulatively built an understanding of boundaries and the impact of management interventions upon them. Starting with the chapter on building theory from theory a three-by-three matrix (Table 2.4) was proposed that related concepts of boundaries as emerging from physical, behavioural and cognitive dimensions to three types of management interventions, contact and awareness building, training and development and building vision. This matrix was

expanded upon in the fieldwork chapter in a number of ways. Firstly the framework was extended by codifying types of boundaries that existed in each boundary category and describing how each category created tensions that had to be overcome to resolve any potential conflict arising from that boundary. These findings were tabulated in tables 5.4 to 5.6 and are summarized in table 10.3 below.

Table 10.3 Types of boundaries evidenced in each boundary category

Physical Boundaries	Behavioural Boundaries	Cognitive Boundaries
Job description	Personal Investment	Work Beliefs
Product set	Work Processes	Belonging
Location	Team Behaviour	
Colleagues	Customer Service	
Owners		
IT system		
Branch manager		

The types of boundaries identified for each category were consistent across both studies and the hospital study confirmed the same set of potential boundaries with the exception of ‘owners’ which is accounted for in terms of the public – private sector orientation of the studies. It is important to note that this set of boundary types represent the differences that *may* exist between the merging organisations and that *may* have the potential to create conflicts. It is not to suggest that they will exist or indeed where they do exist that they will create conflict. For instance it was evident in the financial study that an issue created conflict in one branch but not in another. The boundary types should therefore be considered as a guide to identifying where boundary conflicts may be possible.



The terminology of the boundaries as physical, behavioural and cognitive was derived from the literature on boundaries. However, an ongoing challenge throughout the work and in the presentation and peer-discussion of the research concerned the division of categories at the margins of the boundaries. The division between physical and behavioural labels was most problematic with the point of transition sometimes unclear, for example an original category 'team constitution' was developed to represent the people in the organisation who made up the physical team. However the team also has behavioural connotations (evidenced by the category team behaviour) and it is often difficult to separate the behaviour of the individual from the individual as a member of the team. This debate helped substantially in the refinement of the categories and their constituent boundaries (and their labels); for instance the team constitution boundary was relabeled 'colleague' to represent the more tangible and individual person rather than their underlying behaviour. The data however clearly pointed to a division between the behavioural aspects of work and the artefacts, spatial and environmental aspects. The decision to remain with the term 'physical' to describe these boundaries was taken to emphasise the sense of presence this categories of boundaries represent. Of course, it should be of no surprise that tensions exist between the boundary categories. By creating this framework the boundaries have themselves been bounded by the categories. If we accept the underlying assumption that boundaries are socially constructed and arbitrarily located then these categories, of themselves, are a construction of this work. As such they should create tensions at their edges. However, it should be restated that the purpose of the thesis is to generate insights that help management to intervene successfully in an M&A. The insights do not posit a singularly

replicable model of change but is an invitation to conceive boundary changes as a fundamental issue in M&A integration and to initiate a wider discourse on boundary change given the paucity of existing work.

*10.3.4 Theoretical Insight 4: At least three management intervention types can be related to impacts on boundaries*

The second dimension to the boundary model identified in Table 2.4 was the management interventions that may impact on the boundaries to reduce their likelihood of creating conflicts. Three interventions were identified from the literature, contact and awareness building, training and development and building vision.

Developing the framework from the financial services study suggested a relationship between the interventions and the boundaries and that the interventions had impacts on particular boundary categories. There is a strong case that the interventions can have meaningful impacts on the incidence of boundary conflicts as varying outcomes were evident in individual branches within the study and that these varied in line with the range of interventions adopted by the branch managers. While the intention is not to suggest causal linkages, nonetheless branches that undertook particular intervention actions did have greater levels of task and human integration post-merger. The framework for understanding boundaries arising from the fieldwork is replicated in table 10.4.



This framework was used to develop insights about the challenges faced in the action research study and informed management decisions and actions in that study. Both studies reported similar types of boundaries and tensions. Moreover, the interventions of management were perceived as important and valuable in determining the final merger outcomes by both management and staff<sup>76</sup> in the second study. Validating the work in practice gives strong weight to the theory.

Table 10.4: A framework for managing boundaries in an M&A

	Physical Boundaries	Behavioural Boundaries	Cognitive Boundaries
Type of Tension created by Boundary	From Surroundings	From Interaction	From Affective attachments
Potential For Boundary Conflict where boundary becomes salient	Boundary arises <i>about</i> an issue due to 'unfamiliarity'	Boundaries arise <i>with</i> an action that creates <i>confusion</i> over its appropriateness	Boundaries arise <i>because</i> of a <i>challenge</i> to the value set or identity
Effect of Management Interventions on each Boundary			
<i>Contact and Awareness Building</i>	Builds awareness and familiarity  <i>Positive Effect on Boundary</i>	Staff are aware of surroundings but confused on how to interact within the new surroundings  <i>Limited Effect on Boundary</i>	Staff are aware of surroundings but not how it relates to their values  <i>Limited Effect on Boundary</i>
<i>Training and Behaviour Support</i>	New repertoire of actions but unfamiliarity remains as to how they link to the surroundings  <i>Limited Effect on Boundary</i>	Builds repertoire of actions that can reduce confusion.  <i>Positive Effect on Boundary</i>	New repertoire of actions but not how they relate to values  <i>Limited Effect on Boundary</i>
<i>Building of a Vision</i>	New vision but unfamiliarity remains regarding changes in the surroundings  <i>Limited Effect on Boundary</i>	New vision but confusion in translating vision into actions  <i>Limited Effect on Boundary</i>	Builds vision that allows a new identity and value set to be accepted  <i>Positive Effect on Boundary</i>

The framework represents a contribution to understanding boundaries in an M&A and provides useful insights for managers in practice. The theory explains the relationship between boundaries and impacts on people’s actions through the

<sup>76</sup> The framework was used as one explanation for the success of the study by hospital management in their application to the Health Authority for a service award.

idea of tensions. Tensions are associated with uncertainty. The phenomenon of uncertainty occurring in M&As is well reported (Marks and Mirvis, 1998, 1997a, 1997b; Hubbard, 2001; Hogan and Overmyer-Day, 1994). This uncertainty bring boundaries into focus as differences between merging units become evident and changes in the physical, behavioural and cognitive structure of the organisations occurs. Tensions manifest as individuals and groups grapple with the new arrangements and try to cope with them. The research shows that three separate tensions will occur:

1. Arising from physical changes, the operating environment will change and individuals will struggle to regain a sense of familiarity with their new surroundings.
2. As new behaviours are required, intra-organisational relationships and routines will change and individuals will struggle to establish appropriate ways of interacting within the new arrangements
3. As values and culture changes, organisational identity will change and individuals will struggle to re-identify with the new organisation

The potential for these tensions to create salient boundaries can be mediated by appropriate management interventions:

1. Contact and awareness building interventions will help to reduce tensions arising from unfamiliar settings by exposing individuals to the new surroundings. These interventions will have limited impact at the level of behaviour or cognitive boundaries.
2. Training and behaviour support interventions will impact on interaction tension by supporting new routines and explicit links between tasks,



actions and relationships. These interventions will have limited impact at the level of physical or cognitive boundaries.

3. Building a vision will impact on the cognitions of staff and their association with the organisation by fostering a new identity for the organisation and making explicit their values. These interventions will have limited impact at the level of physical or behavioural boundaries.
4. All three intervention types are necessary to ensure that the boundary salience does not occur. When one or more intervention is missing that boundary category is likely to generate conflict and result in boundary salience reducing integration outcomes.

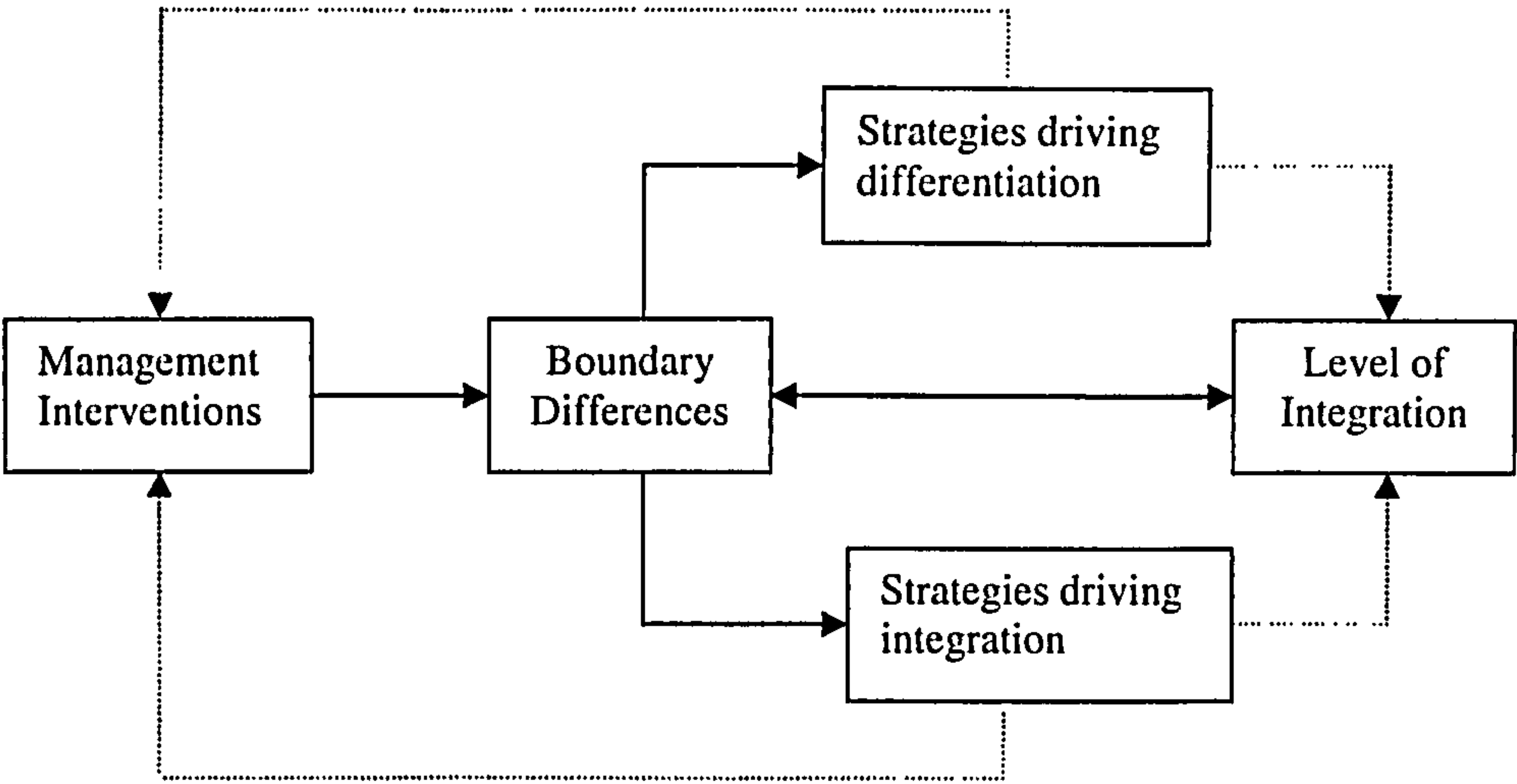
The framework developed here represents a contribution to knowledge about boundaries and their importance in managing M&As. These statements are translated into a practical guide for managers in section 10.4.

*10.3.5 Theoretical Insight 5: The level of integration achieved will depend on the interplay between the management interventions and the strength of the strategies driving integration or differentiation*

The link between the strategies for managing salience (section 10.2.2) and the boundary categories and interventions (section 10.2.3) also needs exploring. The interventions designed to facilitate boundary change, contact and awareness building, training and development and the building of vision, are actions that create awareness, understanding and formation of new boundaries. In contrast the strategies to legitimize or de-legitimize boundary salience utilize the

outcomes of the interventions to create a meaningful context for individuals and groups to justify a social order. This relationship is shown in Figure 10.1.

Figure 10.1 Link between strategies, interventions and boundaries



When boundary differences become salient the overall level of integration achieved will be lower. This has been evidenced throughout the discussion on merger integration (Haspeslagh and Jemison, 1991; Shrivastava, 1986; Nahavandi and Malekzadeh, 1988) and in the financial services study, where boundary differences were evidenced in the less integrated branches. The two studies however show that salience will be a function of two processes:

1. The first process involves *management interventions* that attempt to align the physical, behavioural and cognitive systems by recognising and reconfiguring the operating environments for the combining organisations including impacting on the cognitive and cultural understandings of people within the organisation. The process aligns boundaries and removes the tensions from the uncertain surroundings, interactions and



affective attachments as indicated in table 10.4. This is represented by the black lines in figure 10.1.

2. The second process involves *managing the context* of the organisations. Competing claims to legitimacy are possible within the uncertain environment of a merger and as the hospital study has shown (table 10.2) competing strategies to support the logic of separation or integration are possible. This second process therefore involves generating a meaningful context for the merger by promoting systemic understanding that legitimises the merger and which allows staff to accept that 'legitimacy' over other competing realities. These processes are represented by the red dotted lines in figure 10.1.

These two processes are separate and distinctive (although related) and impact on the final level of integration in different ways. The first cycle will impact on the range and extent of boundary differences. By adopting the intervention types identified in table 10.4, greater homogeneity between merging groups will be created for each boundary category. Boundaries will have less potential to become salient and the final level of integration can be improved because boundaries will be perceived as similar for each group. A similar process has been reported in social identity theory and identity impacts post-merger. For instance, Van Kippenberg and Van Leeuwen (2001) have related continuity of identity as a factor that improves post-merger identification. The financial services study demonstrated how the building of common boundaries served to improve the post-merger integration levels. Similarly, within the financial study, branches with high levels of integration had formed common boundaries and had

removed the tensions associated with the three boundary types. In contrast where branches achieved less integration, there was also less agreement on the similarity of boundaries between the two groups.

The reduction of boundary differences is of itself however not sufficient to create boundary integration post-merger. This was very evident in the hospital study where the same process of boundary management was applied in the two hospitals to varying effect. What was evident in the hospital study is that a second process of context creation was also operating. Not all staff wanted the merger to happen and there is evidence that a strategy to maintain differentiation existed. The strategies driving integration and separation are set out in table 10.2. These strategies competed for dominance throughout the hospital merger. As the dominance of each ebbed and flowed so did the impact of the management interventions. When integration was the accepted norm then the acceptance of boundary similarities was achieved, for example the post-merger position in the hospital. In contrast (as at the end of cycle 1 in the hospital study) where differentiation was the dominant norm for one group, the focus was maintained on strategically selected differences (often outside management control) to reduce the currency and relevance of boundaries that were similar. The strategies to drive integration or differentiation therefore impacted directly on the boundary interventions to give relevance to what was being defined as similar and to the level of integration achieved by helping define the context that allowed groups understand what boundary differences are important.



As a result of these two processes boundary problems can emerge from two independent sources. Problems may emerge from

1. ‘boundary conflicts’ that arise from the failure to generate common boundaries through effective management interventions and
2. ‘reality conflicts’ that are generated because the conflicting strategies of integration and differentiation create alternative realities of what is important to the organisation. When boundary differentiation becomes the dominant reality then conflicts about the relative importance of different boundaries will occur.

A relationship between the two dimensions can be proposed (table 10.5).

Table 10.5: Sources of boundary salience

	Dominant reality		
		Integration	Differentiation
	High	High levels of integration	Integration problematic because of reality conflicts Boundary salience related to strategically chosen differences that support reality of separation
Strength of Management Interventions (level of boundary reduction)	Low	Integration problematic because of boundary conflicts Boundary salience related to conflicts over work related practices and beliefs	Reality and boundary conflicts occur. Multiple causes of boundary salience

Table 10.5 suggests that only one quadrant supports a high level of integration, where both an appropriate legitimizing reality is created and interventions to reduce existing differences and foster new boundaries have been implemented (as happened at the conclusion of the hospital merger). Integration problems will manifest in all other quadrants. The data collected supports the problems encountered in the differentiation-high quadrant (phase 1 of the hospital study)

and integration-low (financial services study) and quadrant 4 is a combination of these two problems. While this table demonstrates the interaction between the two processes as a two by two matrix, in fact both axes represent a continuum and the outcomes presented in the table represent the extreme ends of those continua. Furthermore, as demonstrated in the cases studied, movement along the continuum is also possible (this is another differential between the boundary theory and acculturation models which tend to suggest that cultural preferences remain static). The challenge for managers is to shift both context and boundaries toward quadrant 1.

#### **10.4 Practical Application of the Theory**

In line with action research methodologies generally, the aim of the research is to make a contribution to practice. This contribution arises at two levels. On one level, action research is about making a contribution through the resolution of a substantial organisational problem. The thesis has clearly delivered this in terms of the successful merger of the hospital. On another level, the meta-level, learning should occur that translates the outcomes into useable knowledge. Meta-level learning occurs from self-reflection (and this will be dealt with in section 11.2.5) and from generating theory. The theory discussed above is easily translated into a practical guide for managers of M&As. A six-stage process is proposed. This approach is relevant when high levels of human and task integration are necessary to achieve the objectives of the merger. While the actions suggested are present in sequence there is no attempt to suggest that they are in effect sequential activities. Rather, in line with action orientated research



philosophies, these steps should be seen as a cyclical reflective process of analysis and reflection.

### *1. Codify the boundaries that may have the potential to become salient*

The boundaries identified in table 10.3 provide the template for uncovering the range of boundary possibilities and exploring with the combining organisations what differences are present and might hinder integration. Appendix 11 (table 1) provides a suitable template for the work. This process itself is an intervention of contact and awareness building. Many practitioner models (e.g. Pritchett, 1997) propose initial pre-merger sessions to explore and build understanding. Using the boundary model as a template a detailed analysis of differences and similarities can be used as a frame to build initial awareness of potential problems and build a forum for these differences to be explored. Action research and participative teams would provide a suitable process for these initial sessions.

### *2. Develop an intervention plan*

The development of an action plan involves agreeing the activities that will be undertaken under each of the three headings of contact and awareness building, training and development and building a vision. A template in Appendix 11 (table 2) is presented. The purpose of this template is to ensure that the ranges of interventions adequately address the potential boundary differences and that each boundary class has appropriate interventions. The action plan for boundary management needs to be considered within the wider context of the overall objectives of the merger and the particular activities or units that are merging. The plan should support the merger objectives.

### *3. Develop an understanding of the group dynamics at play*

This research has indicated the critical need to understand the groups that exist within the merging organisations and how they interact with each other. The realisation that the merger between the hospitals actually consisted of three and not two groups, as previously thought, was a turning point in driving the merger. Management must be attuned to the variety of groups and to codify for each one how their particular concerns might translate into boundary issues. What ‘voice’ has authority to shape meaning and define critical issues will be important in determining what issues are likely to be considered as legitimate.

### *4. Contextualise and legitimize*

Uncovering and codifying boundaries and acting to resolve them may be insufficient actions in their own rights and must be supported by a clear shift in the underlying systemic logic of the newly merged organisation. This involves creating a new legitimate social structure and order which supports the changes and serves to de-legitimize boundary salience and reduce conflict. Strategies in increasing order of complexity involve, resolving boundary differences as they emerge, pre-resolving boundary salience by tackling issues before they emerge, isolating particular issues and resolving as a unique case separate from the broader merger issues and finally, repopulating the organisation with new staff who do not share the same boundaries constructs as existing staff.



### *5. Provide ownership through participation*

It has been shown that boundaries are constructed by people and groups. They become salient and create differentiation when individuals or groups are motivated to create and maintain those differences as a means of separating themselves from others. People are therefore central to boundary management and their involvement is critical in enacting new boundaries. A central part of the application of the boundary model within the study was the sharing of problems through participative group structures. In line with Lewin (1948, 1951) the underlying philosophy of change through out this work has been the participation and involvement of people in deciding their own outcomes. The theory developed here has been developed in this mode and accordingly its application should be related to a similar philosophy and tradition. There are also practical reasons why this philosophy should be adopted. The link between boundary and identity is well established as is the link between identity and choice (Tajfel and Turner, 1986). Similarly, authors such as Marks and Mirvis (1998), emphasise the need to provide staff with a means of reasserting their sense of control. Often a merger reduces an individual's perception of choice (i.e. the company the individual is working for) and creates a sense that decision are being force upon them. By incorporating people in decision making and allowing them to resolve problems that are real to them, control is reasserted. Moreover, providing a truly participative structure will, as in the hospital study, provided for more diversity in the decision-making structures and improve commitment, ownership and can ultimately foster learning.

## *6. Reflection as an ongoing process*

The process described in figure 10.1 is an active process of meaning creation with countervailing forces driving and restraining choice, actions and structures. Management interventions must be taken within this political and dynamic context. It is therefore imperative that on-going assessment and reflection are an integral part of any boundary change programme. The objectives established in terms of both the boundary interventions and the more macro meaning creation strategies are constantly reviewed against targets and adjusted as appropriate.

## **10.5 Conclusion**

This chapter has integrated the three pillars of the research and generated five theoretical insights to inform practice in M&A integration. Adopting a boundary approach is appropriate because it attunes managers to potential areas of conflict and allows them to anticipate and manage those potential conflicts. Boundaries are central to integration and merger outcomes can be improved if boundaries are attended to. The five theoretical insights are:

1. Boundary salience occurs through a dynamic political process;
2. Strategies exist to legitimise and de-legitimise boundary salience in an M&A integration;
3. A theory of boundaries can classify boundaries as physical, behavioural and cognitive;
4. At least three management intervention types (contact and awareness building, training and development and building vision) can be related to impacts on boundaries;



5. The level of integration achieved will depend on the interplay between the management interventions and the strength of the strategies driving integration or differentiation.

Arising from these insights it was shown that merger outcomes will be improved when management interventions reduce perceptions of boundary differences across all three boundary categories and when the strategies legitimizing organisational integration dominate over strategies supporting differentiation. These insights can be applied in practice and a six-stage method for applying the insights in practice is presented.

The next chapter will reflect on these insights and consider the overall contribution of the thesis. It will assess the research against the criteria established at the outset to evaluate whether the work has delivered on the targets set and consider the implication of the work for future research and practice.

# 11 Conclusions

## 11.1 Introduction

Evaluating the thesis is a process of assessing whether the work has delivered on the objectives set at the beginning and whether the methodology and method follows an appropriate implementation and analysis framework to ensure quality, trustworthiness and validity, as defined by Herr and Anderson (2005), in the outcomes and outputs of the work. This chapter will review the contribution that has been made by the research. It will address the limitations of the study and describe how the quality indicators discussed in Chapter 4 were achieved. Finally, the implications of the work for theory, practice and future research are discussed.

A fundamental part of any action orientated methodology is reflection. It is therefore fitting that this concluding chapter should contain a section reflecting on the work, its value and its impact on lived experience. Good research should act as an agent for change, no more so than for the individual. This work has resulted in sustainable learning for the action research partner, it has helped the co-researchers learn about their practice and it has enlightened and enriched my own practice in many ways.



## 11.2 The Contribution of the Work

The introduction chapter laid out the expected contribution from the research (section 1.5). It identified four areas in which the work would contribute. These were

1. generate new knowledge through developing theoretical insights into boundaries in M&As, and how they should be managed to maximize the level of post-merger integration;
2. triangulate three stands of knowledge creation to develop theory on boundaries in an M&A;
3. generate new understandings from the exploration of change in a M&A through longitudinal study and through action research;
4. create meaningful impacts within the action research project that result in the delivery of the action research objectives and which fosters double-loop learning.

### *11.2.1 Generation of New Knowledge*

The obvious and most significant contribution of the work is that it addresses the research objectives. The overall research objective set was to determine how can we change boundaries during an M&A integration to improve the potential for success post-merger and within that question additional sub-questions were identified including what boundaries have the potential to exist during an M&A integration, how do boundaries become salient during an M&A integration, and how can management support changes that create new boundary configurations in line with the objectives of the M&A. The research design and analysis has systematically addressed these questions and has delivered answers to all of

them. Table 10.1 in the previous chapter identified the boundaries that have the possibilities to create boundary salience. Figure 10.1 shows how preventing boundary salience is a function of two separate and distinct processes of reducing boundary differences and creating a supporting dominant reality and finally, table 10.2 describes how management interventions can influence boundary formation. Overall, the conclusions have developed theoretical insights about boundaries and their management which will allow management to address boundary issues.

It has been shown that understanding about boundaries in M&A is underdeveloped and the insights generated by the work represent a new contribution to the debate. The value of the theoretical insights is evidenced by the success of the action research study and the stated value derived by the management team.

The work addresses two distinct fields of research, boundaries and M&As. The theory is developed in the context of M&A integration and specifically contributes to the understanding of that area. A boundary management approach offers a new perspective and lens through which the task of integration can be viewed and managed, drawing attention to the importance of identifying and addressing differences across a wide spectrum of organisational facets. By addressing differences through appropriate interventions conflicts can be predicted and resolved. Codifying the strategies for avoiding boundary salience offers practicing managers practical tools as well as theoretical insights. In summary the outputs of the research for M&A scholars include:



1. a contribution to the debates on M&A integration approaches by offering a new lens through which to view the task;
2. theoretical insights that can explain M&A behaviour;
3. theoretical insights that can help managers in practice to understand and act upon the M&A integration tasks and improve merger outcomes.

In addition the work also contributes to the understanding of boundaries more widely, especially within the field of organisational theory and addresses the call for further research to explore boundaries empirically through more inductive and grounded approaches (Heracleous, 2004). The work shows that boundaries are a complex phenomenon and one that has often been overlooked in organisational analysis. The recent attention to boundaries (Paulsen 2003) is an indication that this field is growing in importance as an area of study in its own right. This work contributes to the emerging theory of boundaries by

1. creating a boundary construct that contributes to the debates on the identification, purpose and operation of boundaries in organisational settings;
2. codifying the assumptions that underpin the development of theory on boundaries;
3. reporting unique studies and examples of boundary change that help to understand and explain boundaries and how they impact on individuals and groups;

### *11.2.2 Theory Development Process Adopted*

A second major contribution achieved by the work is the approach adopted in the theory building process. The three pillar approach of building theory from theory, fieldwork and application in practice represents a unique approach. The integration of theory building from both inductive and deductive processes has been commonly reported in the study of applied disciplines (Lynham, 2002) but usually as an iterative process of moving between theory and practice. The advantage of an action research approach is that it allows research to take place in action removing the distinction between theory and practice. The third pillar of the research design extends the method and provides for a unique triangulation of results.

There are also no readily published studies within the M&A field that have adopted an action research approach. The current work therefore represents an addition to the body of literature in this field and extends on our current understandings of M&As from this perspective and methodology. The value of action research approaches are set out in the methodology section and this work might serve to contribute to future exploration of the approach to both theory development and practice. The benefit of the action research approach is evidenced in the reflections on the first intervention cycle when it was realized that our understanding of the social structure within the Cashel hospital was different to what we had conceived. This realisation arose out of variations between the expected and actual outcomes of the cycle, leading us to reflect on and change our approach for the next cycle. The problem, that the same structure and content of communication in each hospital created variation in results, stands



in marked contrast to the conventional wisdom. Shield (2002) for instance, writing specifically about hospital mergers suggests that communication “focusing on the themes, progress and problems of the merger should be shared widely” (p.361). The actions of management in the study did just that but failed to connect with one of the groups. Traditional case study or quantitative approaches may not have uncovered this phenomenon as staff feedback suggested they felt excluded from communications. In this respect the hospital study, by mapping actions and outcomes, adds additionality to our understanding of the phenomenon. The methodology therefore contributes to knowledge by

1. developing theory from theory, fieldwork and in practice providing a triangulated study;
2. applying an action research methodology to the field of M&A study and contributing to the development of action based approaches to M&A research.

### *11.2.3 Unique and Exemplar Study*

Quite apart from the contribution of the action research approach adopted, the longitudinal nature of the studies also contributes to the uniqueness of the work and to the understanding of M&A and boundary phenomenon. The hospital study in particular affords a unique explanation of a pre-merger interaction. Many integration guides advise that the speed of integration is important (Angwin, 2000; Askenas et al, 1998) and urge that integration actions occur rapidly. Usually, once regulatory hurdles are completed organisations are keen to realize value: this is an imperative in most commercial organisations. Rarely therefore is a study capable of exploring a protracted period of pre-merger

activity, in which management interventions, protracted periods of conflict and final integration success are capable of being studied. In the hospital study, the total pre-merger period was 12 years and the actual study recounts the lived experiences within the last four years of that process and almost one year post amalgamation. Reporting of the case and the data captured represents a significant record of a unique case of complexity and change at depth. Further contributions of the study are therefore

1. reporting of a unique case study that represents an extreme exemplar of M&A integration and
2. capturing data in a longitudinal study which enhances understanding of complexity.

#### *11.2.4 Practical and Meaningful Impacts*

Action research approaches, because they are research in action, must also be concerned with the resolution of real problems. The hospital case contained a significant problem. The application of the theory developed in the financial study to the hospital was designed not only to develop theory but to deliver sustainable change within the hospital. As indicated at the outset of the thesis, two forms of impacts are possible from the thesis. The first are outputs which consist of tangible artefacts of the work, such as theories or defined actions. The second impact arises from outcomes, which are sustainable changes that have occurred in behaviour or cognition. The thesis set as a goal to contribute both outputs and outcomes. Sections 11.2.1 to 11.2.3 represent outputs that have been achieved at the academic level. Significant outputs and outcomes have however been achieved at the practice level.



The most significant practical output from the work was assisting in the amalgamation of the hospitals (see appendix 12 for acknowledgement letter). The cycles of actions and reflections contributed to the ultimate achievement of the hospital goals and provided a structured method to deliver on the goals. In this respect the overall imperative of action research methods, delivering on change within a reflective and participative environment, has been achieved and this of itself represents a contribution to practice. However in addition to the output achieved, sustainable outcomes are also evident in the AR work. It was noted in section 3.5 that reflection is the process by which learning occurs (Mezirow, 1991). Learning arises from content reflection; understanding of what has happened, process reflection; how the research was conducted and premise reflection; questioning underlying assumptions. The outcomes achieved in terms of the understanding of M&A integration (figure 10.1) represented an example of content learning and the changes to actions as the cycles unfolded represented a constant evaluation of the process adopted. Of particular note, in terms of premise reflection is the assertion of the hospital management that substantial changes in hospital practice are now evident.<sup>77</sup> The emphasis on team-building, participant-designed solutions, openness and the creation of meaningful dialogue between management and staff has resulted in new behaviours. Meetings have shifted from being places where agendas are played out to become the space where solutions to problems emerge. This represents a shift in cognition as well as behaviour. It would appear that greater awareness of different perspectives, more openness to diverse opinions and an acceptance that compromise is needed

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<sup>77</sup> Based on final reflection meeting with hospital manager and Integration Manager

if hospital-wide outcomes are to be improved upon, now exist. Building trust was a central pillar of the action research work which allowed issues to be brought to the forefront in a constructive manner. This was also strongly evident in the self-assessment accreditation review conducted in the hospital, post-merger. Staff related their own activities to the broader hospital and understood their relationships to others within the totality of the hospital. Since (and as part of) the merger, the hospital has created new committee structures, new decision making bodies and restructured its clinical operations devolving greater levels of autonomy and control. Early evidence from these actions suggests that the new understandings developed by staff throughout the amalgamation period will translate into long-term changes. These changes represent not just improvements in individual practice (double-loop learning) arising from new understandings but deeper systemic change within the hospital structures.

#### *11.2.5 Reflection on the Action Research Process*

This work can also make a contribution to the practice of action research. The work extended for a period of over four years and throughout that time the relationship between me and my co-researchers matured and developed. We developed from a tentative understanding of how we should work together to a clear co-researching partnership that helped deliver the merger outcome. It is worth therefore reflecting on how my role as an action researcher changed during that period and whether there are lessons for action researchers that can be proposed as a result. Three issues are particularly relevant in how practice of my action research developed.



Firstly, the original letter of engagement was drafted with the intention of working through the executive team. However, my role grew and evolved in ways that could not have been anticipated. Fairly quickly the 'team relationship' became secondary to the relationship that was developing between the key decision-makers and me. These decision-makers sought support in the processes issues that they were dealing with and my role quickly became a sounding board for them to discuss and plan actions. I was happy with this role as it engaged the process consultation model (Schein, 1999) and allowed me to help with but not direct change. Central to these relationships developing was the range of activities that I became involved with. As noted in section 7.7 I received many requests for support across a range of activities that were not directly associated with my role as an action researcher. These included writing text for newsletters, being a committee member for the accreditation review and helping develop a mission statement. Many of these activities shifted my role from process consultant to expert consultant. I had therefore to manage multiple roles particularly when engaging staff more widely (although the majority of my work was with a limited number of staff such as the co-researchers and executive team) and be conscious of their perceptions and expectation of the intervention. However, engaging these additional roles helped substantially in understanding the organisation and in developing trusting and productive working relationships with key people. They provided additional insights because they opened up the wider organisational systems, processes and cultures and allowed me see the organisation in new perspectives (i.e. the consistency in professional values or the team spirit in the accreditation process) and while these were not central to the amalgamation process they nonetheless were hugely helpful in framing issues

and building relationships. A lesson from this is that whatever the planned design of the action research there will be additional relationships that will develop around activities and tasks. The action researcher must be cognizant that these are additional and possibly conflicting tasks however there is also potential gain if they are engaged. A key reflection for action researchers is therefore that:

*The action researcher should be ready to engage multiple activities as an aid to contextualizing the research and building meaningful relationship but must do so in the recognition of the dilemmas that inevitably arises from engaging different helping modes.*

A second learning for me was the extent to which multiple modes of reflection were used to support the case decision-making and thesis development. Section 3.6.1 and 7.7 outline the decisions made to incorporate writing and feedback as reflection modes in order to ensure that the academic study directly engaged the co-researchers. Reflection also developed, organically, in other ways, for instance the proposal to apply for a service award resulted in a wide cross functional team coming together to discuss the merger outcomes. Over the life of the project reflection occurred through, individual discussions with the co-researchers, discussions with the co-researchers as a team, discussions with wider groups such as the executive team and through writing text (academic articles and general observations) for review. Similarly, feedback sessions with staff when data was being reported also served to provide reflection. These multiple modes of reflection helped to form an overall picture and generated multiple means of understanding phenomena. Action researchers may therefore be advised that



*The action researcher should be aware of the multiple ways in which reflection can be enhanced by engaging groups or individuals and should seek to improve practice by engaging as many methods of reflection as possible.*

Finally, the delivery of this action research could not have occurred had the strength of the relationship that was built between the research team not been developed. I believe two factors created the high level of trust. Firstly, both the co-researchers were extremely open and learning orientated people (incidentally both engaged and obtained advanced academic awards during the merger) which made the development of trusting relationships easier. Indeed, the Hospital Manager actively sought to build a climate of trust within the hospital and accredited much of the success of the merger to this strategy. The second issue for trust development was the manner in which we confronted issues head-on. For instance, section 7.7 identified some of the dilemmas that we faced as a co-researching team. The resolution of these dilemmas involved willingness for us to acknowledge them and discuss them. Furthermore this willingness was all the more important because the issues emerged from the activities and events and as such occurred in an unstructured and unanticipated manner. Even with the greatest of hindsight all the dilemmas and issues we faced as a co-researching team could not have been legislated for in advance. Hence it is important that the action researchers acknowledge that:

*Strong action researcher/co-researcher relationships require an open and trusting environment in which dilemmas or problems can be surfaced*

*and discussed because it is impossible to legislate in advance for all eventualities.*

#### *11.2.6 Personal Reflection and Development*

It is worth noting that as an action researcher the process of reflection impacts on my own understanding both of the phenomenon under investigation (reflected in my interpretation of the case and the data) and on my practice and assumptions. This latter issue is not a core objective of the thesis and as such is secondary to the main theme of understanding how boundaries change. However, my own practice and understanding have changed over the period of study. Noteworthy reflections include my understanding of the relationship between progression and resistance to change. Like many people I sometimes find it frustrating when others fail to engage change processes or flatly reject change for the apparent sake of being opposed to it. I always assumed such resistance as being anti-progression. The rejection of change was evident in the action research study. Initially, I found it hard to reconcile the supportive caring environment of the hospital and its health professionals with a position that rejected improvements to patient care and overall services. It is easy to assume that resistance is due to personally motivated factors unrelated (or at least loosely coupled) to 'corporate objectives.' As the study unfolded, deeper understandings of the context of people emerged and a deeper questioning of my own assumptions and beliefs occurred. Discussions with the Hospital Manager and the Integration Manager often took the form of questioning why people were acting in particular ways and why they resisted change. We explored rationale for the positions taken by a group or individual trying to uncover tactical positions underpinning a particular



agenda. We talked a lot about control, identity and relative power, recognising the disruption that the merger would cause to existing relationships and work processes and outcomes. As the discussions unfolded I began to question my own assumption about progression. Our discussions were not about resistance to progression but represented an alternative philosophy about who had the rights to define the progression agenda. I realised that I had implicitly made a value judgement, viewing as dysfunctional anybody opposed to the merger. I began to fear that my assumptions on progression were hegemonic. By defining the change agenda, by mapping the route by which progression might be measured, I was imposing a dominant perspective of what reality should exist. These realisations had an impact on my behaviours. Most evidently in a renewed determination that I must ensure I do not make implicit value judgements in my interactions or imply them in my comments.

Another issue of reflection and personal insight involved the issue of control. Perhaps as part of my management training and background experiences, I like to lead and maintain control of the environment, as a researcher and a collaborator maintaining that control is problematic. In recognising the need for control, I became minutely conscious of the relationship between control, power and manipulation. As researchers we must control our research but we must not manipulate our co-researchers or participants. This had significant implications in terms of relationships with the executive transfer management team as I played the dual roles of researcher and executive team member. One instance, shortly after the team had been established made me realise the impacts that I might have on them. During an executive transfer team discussion on

communication and engagement in the transfer process, I commented that best practice on communicating on an M&A usually recommends strong and continual organisation wide communication and that if they followed (as they were) that model of communicating then they could expect good communication outcomes especially given the myriad of channels they were using. The subsequent minutes of the meeting recorded “Mr Derek O’Byrne said that the methods of communication that are in place in South Tipperary are second to none.”<sup>78</sup> I got the minute corrected the following week to read ‘*in line with best practice*’ rather than second to none but the ease of unintentionally influencing behaviour or outcomes became very clear to me. I had intended my comments to stimulate a discussion on the range of communication channels not as a validation of other people’s action. As a result I resolved to be conscious of behaviour in a number of ways:

- a. I became more explicit about my roles and relationship and their boundaries as part of interactions.
- b. I began to listen more and say less taking ownership of an issue only if the roles and relationships around it were negotiated and agreed.
- c. I began to question assumptions more explicitly about what others are thinking or want by asking them directly. It improved my practice of relating proposed actions to objectives by asking people, why are you doing this?
- d. Arising from the anecdote quoted above I realised the potential in my own practice to lay claim to a position of authority in interactions and this awareness has reduced the potential for that to occur.

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<sup>78</sup> Minutes of Executive Team – Amalgamation of Acute Services South Tipperary, 6th May 2005 (South Tipperary General Hospital, Clonmel).



I was lucky to have experienced the level of cooperation within the hospital study which was a very open place and in which discussing everything was possible. I learned a lot from the interaction with the Hospital Manager whose openness afforded me great comfort and support in pursuing an open participative agenda and indeed she taught me a lot about real collaboration. My relationship with the hospital management team has developed and matured over time and our engagements have developed a strong bound of trust which I hope will have enduring strength to foster ongoing action research. Indeed trust building was a cornerstone of the approach the Hospital Manager and her team adopted in managing within the hospital. Within our reflection she accredits much of the change success to trust and perhaps this represents a significant issue for future exploration in our actions and research.

My personal interest in the research question was noted in the introduction chapter. In my own practice I have regularly experienced boundary problems in leading change and I have struggled to understand how boundaries emerge and can be managed. This research has helped my practice and understanding of boundaries. I realise that the application of 'sound logic' to change is insufficient in its own right to motivate, in all instances, individuals to accept new boundaries. I am now more aware of the role boundaries will play in protecting a meaningful context for individuals or groups and that resistance is not necessarily aimed at preventing change but at preserving a social order. Logic for change must be viewed from the perspective of multiple social orders and to give hegemony to one perspective is to deny the legitimacy of others. Yet as

managers of social systems it is our role to direct those systems, whether commercial or public service, to a given output. We must meet profit targets, service levels and respond to superior instruction. Within this, as managers, we must recognise conflicting obligations, ensuring that we do not deny the legitimacy of others' views while often, simultaneously, dominating those others' views to achieve a predefined outcome. I now believe this is an issue of means and outcomes. Sometimes we have no choice in the outcomes, the hospital had to merge, but we do not need to specify the means. Adopting a democratic method that allows alternative perspectives to engage clearly offers the opportunity of agreeing a new social order. However, not everyone can always engage a new social order. Perhaps the most traumatic issue for me within the research was listening to one individual express, in very emotional terms, how she could neither transfer to the new hospital because of family commitments nor face changing the job she had done for many decades to work in an area of care (elderly or palliative) that terrified her. This was an individual who faced an extremely difficult personal choice that had no apparent up-side. It was inevitable that the merger would result in a distressing outcome for her. The reality of work organisation is that we are often dominated by external demands and we have limited capacity to choose our own course (unless exit is an option). Perhaps I have not always considered the damage that organisations can do to individuals or recognise my duty of care to people who, for many reasons, may be unable (rather than unwilling) to transcend existing boundaries and accept change.



### **11.3 Implications of the Research**

The contributions of the research to the development of theory in the fields of M&A and boundary management as well as the methodological contributions have been laid out in sections 11.2.1 to 11.2.3. These contributions have implications for academics and managers and suggest directions for possible future research directions. This section will explore these implications.

#### *11.3.1 Impacts for Theory and Practice*

M&A scholars have traditionally downplayed the impacts of boundaries on merger outcomes conceiving them as part of organisational design rather than active components of the merger integration process (e.g. Haspeslagh and Jemison 1991; Hubbard 2001; Kapoor and Lim, 2007; Capron; 1999 and Lars 1999). This research clearly shows the complexity of the boundary task. Conceiving boundaries as not-problematic is oversimplifying the role of boundaries in achieving merger outcomes. This work points to the dynamic nature of boundaries and their capacity to be used as a strategic weapon, either supporting or resisting change. Theorists and practitioners within the M&A field need to be far more cognisant of the boundaries that might exist and more importantly how those differences might be used by interest groups to further their aims.

Theory on boundaries is at a nascent stage of development and few systematic attempts have been made to codify a theory of boundaries or of boundary management. This thesis takes a step in that direction and demonstrates how

boundary theory might be developed and applied. Boundaries are pervasive and complex and as demonstrated in the research influenced by contextual and political forces through a dynamic interplay of social interaction. This work has however been able to create a useful framework for application of a boundary approach that can help managers identify differences within the context of an M&A and to apply that framework to productive effect. Despite their complexity boundary analyses can have positive outcomes. Two issues stem from this. Firstly, should we be seeking a grand theory of boundaries, are all boundary situations the same and can management of boundaries be universally applied across social structures? This work has identified the set of assumptions that underpin the development of theory in boundary management (section 2.3) but these represent assumptions about the nature of boundaries rather than how they change. A clear implication of this research is by focusing on specific change events that are rich in boundary change, theory on boundaries, more generally, can be constructed. For example the finding that boundary salience can be managed by particular strategies could be generalised to other situations as a means of understanding boundary conflicts. By exploring boundary change in multiple contexts perhaps a more general theory of boundaries can be built. Several contexts come to mind, including organisational downsizing, changing work patterns (i.e. part-time working), privatisation of public organisations and the influx of migrant workers into traditional nationally dominated organisations. The more contexts that are examined the greater the accumulation of practice from which to build boundary theory.



### *11.3.2 Future Research*

Given the exploratory nature of this research and its focus on theory building, it is not surprising that the research poses perhaps more questions than it answers. The work offers numerous research opportunities to extend the existing work and to develop additional streams of thought and research.

The two studies reported here are unique in their own right and accordingly there are a number of ways in which the work could be extended:

1. The model adopted in the research will be more robust by extension in new action orientated M&A contexts. By further replication the strength of the theory can be enhanced and new insights emerged from the particular unique contexts of each M&A.
2. It would also be interesting to apply the boundary construct to different change contexts, such as restructuring or growth. This would provide contrasting contexts and possibly uncover differing importance within boundary categories and boundary types for differing change environments. For example perhaps the cognitive boundaries during a restructuring are quite different from a merger as the challenge will be to organisation position rather than organisational identity.
3. A significant area for future research is exploring the boundaries of the boundary categories. As indicated earlier the division of boundaries into physical, behavioural and cognitive is of itself a process of bounding. This work does not address what happens at the point of intersection that defines each category or how issues might (or whether they can) transition from being one type of boundary to another. It might be a

fruitful exercise to study the genesis and pathology of boundary conflicts against the theoretical framework of boundaries developed in this study.

The study also suggests a number of new areas for potential study that might enhance our understanding of M&As and boundaries.

Firstly, the reflections with the hospital management team placed great emphasis on the development of trust, particularly between the leader and the hospital staff. Trust provided a potential bridge that allowed diversity to be expressed and explored. The relationship between leader-trust and M&As has not been explored (although justice theory and trust more generally has been applied to M&A analysis, e.g. Hubbard, 2001; Stahl 2005). This would represent an interesting avenue for developing boundary theory; lack of trust clearly creates conflict and may foster boundary salience between individuals and groups but does trust reduce the potential for boundary salience?

Secondly, the thesis has identified strategies used to foster boundary separation (and build integration). However, it does not answer the question of how these strategies are initiated or by whom. A number of explanations are possible. For instance, strategies may emerge from the social structures; part of the process of social reproduction. A threat to the social order might initiate an organisation-wide defence routine to protect and repel that threat. They may also stem from the particularistic concerns of a dominant group or individual manoeuvring to protect the current power or social structure or from the threat to identity.

Exploring the origins of strategies would contribute to the understanding of the



motivation to resist change. It would also enhance understanding of how boundaries become salient and perhaps how earlier management interventions might reduce the perceived need to resist change.

#### **11.4 Limitations of the Study**

As with all research projects there are a number of strengths and limitations that the research design creates. Section 4.5 has already discussed the limitations arising from the method choices. These included the

1. trade-off between depth and breadth in the study;
2. pragmatic choices made in respect of the numbers of participants engaged in the cycles of action and reflection;
3. problems arising from the use of questionnaires as an instrument of data collection in a constructivist epistemology;
4. low response rates to the initial questionnaire data and problems emerging from availability of staff to re-interview as part of the longitudinal design.

At a broader level the thesis also has limitations in the extent to which the knowledge claims can be generalised beyond the data and cases studied. The purpose of the study is to build understanding about boundaries in M&A and to develop a set of theoretical insights. These findings help us to understand how boundaries operate within the contexts of the studies. They do not purport to have a wider generalisability in that they do not define causal relationships between variables. This is a distinction to be made between generating theory, understanding how something operates, and building a model, defining cause-

effect actions. A limitation, therefore, of this work is that it does not create a model for boundary management. Instead it has generated a set of theoretical insights that explain certain aspects of boundary behaviours and how actions might influence events. While the framework developed does not specify causal relations it is nonetheless valuable as a means of understanding events and guiding behaviour. It is for that reason the thesis proposes a practical guide from the theory developed rather than a model of management.

A further potential limitation of the work is the degree of complexity that it incorporates. While in many ways the in-depth longitudinal nature of the studies is a strong characteristic of the work it also serves to extend the work beyond the normal parameters of a thesis. This weakness occurred out of the elongated merger process in the hospital that took three years longer than the research design anticipated. This is a problem in any longitudinal research design that cannot control the exact timing of the phenomenon under investigation.

Finally, a potentially weakness is that the study crosses private and public sector applying theory developed in one to the other. This is a weakness insofar as the contexts are separate and distinct and the operating and regulatory environment is different (La Piana and Hayes, 2005). Contrasting between the two is therefore problematic. However, the study is about inter-group actions and differences within context rather than across contexts. Context differences exist between the public environment of a hospital and a commercial organisation, such as the strong unionisation, vocational identity and dependence on state funding, but these are context factors within the study and do not impact on the analysis of



how the application of the theory developed in the financial study influenced outcomes in the hospital at the intergroup level.

### **11.5 Evaluating the Thesis**

The challenges in managing merger integration are substantial. Poor integration management is increasingly recognised as a cause of poor merger results. If appropriate levels of integration are not achieved, corporate objectives cannot be delivered. Exploring integration from a boundary perspective opens up new and exciting prospects for uncovering potential conflicts, for explaining resistance and for making focused and effective interventions. By codifying the differences that create boundaries, management can design early interventions to prevent boundaries becoming salient. Furthermore, through understanding the dynamics that foster and reduce boundary salience greater attention can be focused on creating an appropriate environment to deal with resulting conflict or resistance.

The work has clearly produced a number of contributions to practice and to the participants within the action research project. These include:

1. The merger of Cashel and Clonmel hospitals to create a new South Tipperary General Hospital was achieved.
2. Double- loop learning emerged within the hospital community.
3. My own practices and awareness were impacted by the research and I learned to change behaviours in significant ways.

This research makes a contribution to the fields of M&A and boundary theory and has resulted in the development of new theoretical insights into M&As and boundary management. The approach of mixing action orientated with inductive and deductive approaches has extended the range of the work giving greater confidence in the 'trustworthiness' of the findings. As indicated in section 3.8 trustworthy involves the demonstration that the researcher's interpretation of the data are credible or 'ring true' to those who provide the data (Lincoln and Guba 2000).

Herr and Anderson (2005) develop five criteria for ensuring quality as indicated in table 3.3 and how this was used to ensure quality within the action research design was shown in table 4.4. Table 11.1 relates these quality measures to the outputs and outcomes achieved in the dissertation. From these it can be seen that the work achieves a high standard of quality delivering on each of the quality measures.

The financial services study was conducted as a standardised case study inquiry. The quality assurance measures associated with the execution of that study included the development of a case protocol, formal transcription of all interviews and the development of a coding analysis guide, which allowed coding confirmation through re-coding of the data. Subsequent publication of the article on the study and the analysis was offered to senior management in the study for comment but no comments were received. Finally, the study was published as an academic article (O'Byrne and Angwin, 2003) and as a book chapter (O'Byrne, 2007).



**Table 11.1: Quality criteria achieved in action research study**

<b>Quality Criteria</b>	<b>Definitional Measure</b>	<b>Key achievements in studies</b>
<b>Outcome validity</b>	Resolution of the phenomenon under study	<p>Hospital successfully merged</p> <p>Cycles of objective setting, action and reflection implemented</p> <p>Hospital won service award for implementing the change</p>
<b>Process validity</b>	<p>Process supported meaningful outcomes for participants</p> <p>Inclusion of multiple perspectives through triangulation</p> <p>Meaningful accounts produced</p>	<p>Sustainable learning evident in case study</p> <p>Positive learning for researcher leading to changed practices (double-loop learning)</p> <p>Multiple sources of data used including questionnaires, narratives, reflective sessions and interview collection</p> <p>Co-produced papers with co-researchers. Final feedback session to 'confirm' accounts rang true</p>
<b>Democratic validity</b>	Involvement of problem owners	<p>Management team acted as action research co-researchers.</p> <p>Participative structure created in hospital through which all change was achieved</p>
<b>Catalytic validity</b>	<p>Realise value of AR approach</p> <p>Deepen knowledge of the social reality and move people to action</p>	<p>Participative structures and AR process have been institutionalised in the hospital</p> <p>New work patterns developed and deep learning about hospital operations evidence</p>
<b>Dialogic validity</b>	<p>Evidence of peer review</p> <p>Sharing of results with participants and dialogue on meanings with community and with peers</p>	<p>2 academic conference papers produced (O'Byrne, Kavanagh and Angwin, 2005 &amp; O'Byrne, Angwin and Kavanagh, 2006)</p> <p>All data collection cycles involved feeding back results to hospital executive and all staff</p> <p>Discussion of study at international action research workshop (AOM Atlanta 2006)</p>

## 11.6 Concluding Comments

Boundaries are an integral part of our lives yet only recently are researchers focusing on how they shape and impact in organisational settings. This thesis contributes to this emerging debate. By codifying the boundaries that exist and classifying them into categories and codifying the management interventions that can address these boundaries, M&A Integration Managers have a new tool for

identifying and resolving potential post-merger conflicts. I have argued that the value of any theory lies in its usefulness in practice and have shown how the use of boundary theory has helped merge a complex organisation in practice by helping managers codify and design interventions to address potential boundary differences. In this way the work has succeeded in its aims of contributing to new knowledge and effecting sustainable organisational change. It has established theoretical insights about boundary change in M&As and has facilitated the development of practical advice to managers of M&As. Its contribution is to a new area of study and hopefully marks the start of a new debate on boundaries in M&A.



## 12 Bibliography

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## **13 Appendices**

**Appendix 1: Interview Schedules: Financial Services Study**

**Appendix 2: Interview Protocols: Financial Services Study**

**Appendix 3: List of Meetings/Events in Hospital Study**

**Appendix 4: Letter of Engagement for the Hospital Study**

**Appendix 5: Ethical Clearance Application to HSE**

**Appendix 6: Ethical Approval Letter of Grant**

**Appendix 7: Schedule of Interviews: Hospital Study**

**Appendix 8: Interview Protocol: South Tipperary General Hospital**

**Appendix 9: Questionnaire Hospital Study (March 2005)**

**Appendix 10: Questionnaire Hospital Study (May 2007)**

**Appendix 11: Templates for Application of Boundary Approach to Merger  
Integration**

**Appendix 12: Letter of acknowledgement from South Tipperary General  
Hospital**



**Appendix 1: Interview Schedule: Financial Services Study**

**Background Interviews**

Int No.	Date	Informant Position	Purpose
1	14/8/01	Integration Manager	Initial Meeting
2	04/10/01	Integration Manager	Discussion and data collection examination of internal documents
3	8/11/01	Integration Manager	Update and final agreement on research design
4	18/4/02	Discussion with regional manager	Email and phone exchange as context for research

**Branch 1**

Int. No.	Date	Informant Position
5	11/4/02	Manager
6	18/4/02	Officer CAP
7	18/4/02	Cashier CAP
8	18/4/02	Ass Manager RTL
9	18/4/02	Grade 1 (Cashier) RTL

**Branch 2: Pre Merger**

Int. No.	Date	Informant Position
10	23/4/02	Manager
11	2/5/02	Senior grade RTL
12	2/5/02	Ass Manager RTL
13	10/05/02	Ass Manager CAP
14	10/05/02	Staff CAP

**Branch 2 Post Merger**

Int. No.	Date	Informant Position
	Not available	Manager
	Transferred	Senior grade RTL
15	31/07/02	Ass Manager RTL
16	31/07/02	Ass Manager CAP
	Long term sick	Staff CAP

**Branch 3**

Int. No.	Date	Informant Position
17	07/08/03	Manager
18	07/08/03	Ass Manager (RTL)
19	07/08/03	Staff (CAP)

**Appendix 2: Interview Protocols – Financial Services Study**

**Interview Protocol: B1 Branch Integration - Managers**

**Instructions:**

This research is concerned with exploring the responses of the individual branch to the integration. Specifically it is interested in

1. Understanding the culture and identity of the pre-combining branches & of the new firm
2. Exploring the similarities and differences between the pre-combining branches
3. Exploring the process by which branches have moved from their pre-combined state to the post combined state and the critical factors that have shaped that process

*The answers to questions should be given from your perspective as a member of this branch/former member of the pre-merger company. Unless asked otherwise.*

Please be honest and open. This is a professional research project and is guided by the appropriate professional code of ethics. All interviews are being treated in accordance with a strict code of anonymity. All confidential material or comments will be treated in strict confidence.



### **Section 1: Process of Integration**

1. Maybe you could start by telling me about the integration process and how effective that process has been to-date.
2. Are there major events or incidents that have been significant in the integration of the two branches to date?
3. How successful do you think the process has been in terms of individuals/branches and the company? Why?
4. What impact has the integration had on the staff?
5. To what extent do you feel part of a new company Merged Co., and the staff?
6. Do you see this firm as a continuation of the former branch or as something new, why?
7. Is the branch view of the merger the same as the centralised or head office functions or other parts of MERGED CO – explain.
8. Is managing MERGED CO staff different from RETAIL CO, Why?

### **Section 2: Culture and Identity of the Pre-Merged Company**

1. How would you describe the former pre-merger branch you worked for?
  - a. Tasks/activities?
  - b. Characteristics (personality, skills, background etc) of staff member
  - c. Culture
2. Was there anything that marked this branch as unique or different (from other branches/banks)?
3. Are there any aspects of the old pre-merger firm that you would least like to lose in the new firm? Explain.
4. What would you like to acquire most from the new firm, if anything. Do you admire anything about the partner firm?
5. How do you think staff in the partner branch see/saw this branch? Has that changed?
6. How would you describe the partner branch you were merging with?

### **Section 3: Similarities and Dissimilarities**

1. What is working for Merged Co, like and how is it similar/dissimilar from the previous branch
2. In terms of the CAP CO & RETAIL CO pre merger, what were the main similarities and dissimilarities between the two branches, in your opinion?

## **Critical activities**

1. What impact has the following had on the process
  - a. Time gap between the announcement Dec 00, completion Apr 01
  - b. The company name
  - c. The newsletter
  - d. The road shows
  - e. Training sessions
  - f. The appointment of managers at MERGED CO & Branch levels
  - g. Previous change initiatives
  - h. The 'physical' move
  - i. The branch lay-out and design
  - j. Work practices

**Thank you for your time.**



## Interview Guide: B1 Branch Integration - Staff

### Instructions:

This research is concerned with exploring the responses of the individual branch to the integration. Specifically it is interested in

4. Understanding the culture and identity of the pre-combining branches & of the new firm
5. Exploring the similarities and differences between the pre-combining branches
6. Exploring the process by which branches have moved from their pre-combined state to the post combined state and the critical factors that have shaped that process

*The answers to questions should be given from your perspective as a member of this branch/former member of the pre-merger company. Unless asked otherwise.*

Please be honest and open. This is a professional research project and is guided by the appropriate professional code of ethics. All interviews are being treated in accordance with a strict code of anonymity. All confidential material or comments will be treated in strict confidence.

Ask permission to record

### Background Information

Time with branch:

Experience before then:

Position:

### **Section 1: Process of Integration**

1. What does this merger mean to you?
2. How successful do you think the process has been in terms of individuals/branches? Why?
3. Are there major events or incidents that have been significant in how or why you form that opinion?
4. If you had to sum up the merger by one event that has occurred what would it be? And why?
5. To what extent do you feel part of a new company Merged Co.? Rate in on a scale 1 – 10.
6. Do you see this firm as a continuation of the former branch or as something new?
7. In what ways is the branch new / continuation?

### **Section 2: Culture and Identity of the Pre-Merged Company**

1. How would you describe the former pre-merger branch (name) you worked for?
  - a. Tasks/activities? Characteristics (personality, skills, background etc) of staff member & Culture
2. Was there anything that marked this branch as unique or different (from other branches/banks)?
3. If you were asked to create a stereotype description of a member of your former branch – what would it be and why?
  - a. What traits/behaviours/way of thinking
  - b. What did it mean to be a staff member of this branch?
4. How has that changed in the new MERGED CO?
5. Why has that change occurred?
6. How would you describe a stereotypical picture of your partner firm?
7. Are there any aspects of the old pre-merger firm that you would least like to lose in the new firm? Explain.
8. What would you like to acquire most from the new firm, if anything. Do you admire anything about the partner firm?
9. How do you think staff in the partner branch see/saw this branch? Has that changed?



### **Section 3: Similarities and Dissimilarities**

1. What does it mean to be a staff member of MERGED CO?
2. How is it similar/dissimilar from the previous branch?
3. In terms of the CAP CO & RETAIL CO pre merger, what were the main similarities and dissimilarities between the two branches, in your opinion?
4. To what extent has the best of both being achieved? What does the best of both mean to you?
5. Do you prefer being part of MERGED CO or would you rather be still part of your former branch?

### **Critical activities**

1. What impact has the following had on the process
  - a. Time gap between the announcement Dec 00, completion Apr 01
  - b. The company name
  - c. The news letter
  - d. The road shows
  - e. Training sessions
  - f. The appointment of managers at MERGED CO & Branch levels
  - g. Previous change initiatives
  - h. The 'physical' move
  - i. The branch lay-out and design
  - j. Work practices

**Thank you for your time.**

## **Interview protocol – Financial services Study**

### **Longitudinal Studies – 2<sup>nd</sup> interview**

#### **Section 1: The Process**

1. Perhaps you can start by telling me about the Amalgamation and how that has proceeded since the initial discussion.
2. What has changed since the amalgamation date? What differences in procedures/people have you witnessed since the amalgamation?
3. What problems/issues arose on or immediately after the date?
4. What problems/issues if any have been emerging over time since the amalgamation date?
5. Has the integration proceeded as you expected. What unanticipated or unexpected events occurred?
6. What effect did the integration team from HO have on the process?
7. Where did people go for physical / emotional support?

#### **Section 2: Culture**

1. How would you describe the culture of the branch at this stage?
2. How has it changed?
3. Did any differences between the RETAIL CO and CAP CO emerge since the amalgamation?
  - a. The way business is done
  - b. The way staff approach work
  - c. The attitude to customers and colleagues
4. How does the current MERGED CO culture differ from your former branch?



### **Section 3: The level of Integration**

1. How well integrated are the two former branches at this stage, in terms of
  - a. The extent to which the job processes of a former CAP CO can be performed by a former RETAIL CO and vice versa. (ie mortgage/cash)?
  - b. The ability to use the software etc ?
  - c. The level of social integration and teamwork between former groups?
  - d. The team?
2. Customer service was a major point in the last discussion. How has that fared?
3. To what extent do you feel part of Merged co?
4. Is MERGED CO what you expected?
5. What has helped or hindered the level of integration?

### Appendix 3: List of meetings/events in hospital study

**A summary of meetings held with staff and their principal outcomes.**

Date of Meeting	Venue	Attendance	Purpose
17 <sup>th</sup> Nov 2003	Clonmel	General Manager	Discussion on the research
29 <sup>th</sup> Nov 2003	Clonmel	Assistant Gen Manager	Introduction & Tour of Clonmel faculty
5 <sup>th</sup> Dec 2003	WIT	Assistant Gen Manager	Follow-up meeting to background briefings
2 <sup>nd</sup> Dec 2003	Cashel	Assistant Gen Manager	Tour of Cashel
22 <sup>nd</sup> Dec 2003	Clonmel	Integration Manager	Discussion on the amalgamation process
13 <sup>th</sup> May 2004	Clonmel	Assistant Gen Manager	General background to hospital
4 <sup>th</sup> June 2004	Clonmel	Director of Nursing	Discussion on issues from a nursing perspective
14 <sup>th</sup> June 2004	Clonmel	Executive Committee	Executive Committee Meeting
9 <sup>th</sup> July 2004	Clonmel	Executive Committee	Executive Committee meeting
20 <sup>th</sup> Aug 2004	Clonmel	Integration Manager	Discussion on the amalgamation progress and on newsletter production
7 <sup>th</sup> Sept 2004	Clonmel	Integration Manager	Discussions on partnership process and on newsletter contents
22 <sup>nd</sup> Oct 2004	WIT	General Manager	Discussion on progress and setting targets & preparation for next steering meeting
29 <sup>th</sup> Oct 2004	Clonmel	General Manager & Integration Manager	preparation for next steering meeting
1 <sup>st</sup> Nov 2004	SEHB Kilkenny	General Manager	Agreeing actions
5 <sup>th</sup> Nov 2004	Clonmel	Executive Committee & private meeting with General Manager	Executive Committee Meeting
13 <sup>th</sup> Dec 2004	Clonmel	Integration Manager	Discussions on partnership process and on communications
6 <sup>th</sup> Jan 2005	Clonmel	General Manager & Integration Manager	Preparation for next Executive Committee and for detailing project plan to completion
12 <sup>th</sup> Jan 2005	Clonmel	General Manager & Integration Manager	Cancelled steering meeting and used time as means for discussing progress
20 <sup>th</sup> Jan 2005	Clonmel	Executive Committee	Managing progress
7 <sup>th</sup> Feb 2005	Clonmel	Integration Manager	Progressing Questionnaire & update
15 <sup>th</sup> Feb 2005	St. Patrick's Waterford	Partnership Facilitator	Discussion on partnership process/ integration days / feedback
1 <sup>st</sup> Mar 2005	Kilcoran Hotel	Group of Staff, incl. Partnership Facilitator, General Manager and Union Rep	Integration day – observational role only.
30 <sup>th</sup> Mar 2005	Clonmel	Integration Manager	Discussions on progress and the achievements to date



1 <sup>st</sup> April 2005	Clonmel	Executive Meeting	Managing progress
April 2005	Clonmel	Integration Manager	Discussions questionnaire data & their interpretations
April 2005	Clonmel	General Manager & Integration Manager	Pre-exec meeting and discussion on the questionnaire
April 2005	Clonmel	Executive Meeting	Managing progress
June 2005	Clonmel	Exec Meeting	Managing progress
July 8th	Waterford	Meeting with Integration Manager	Strategy for newsletter
18 <sup>th</sup> Sept 2005	Clonmel	Integration Manager (apologies General Manager but brief meeting and email subsequent)	Review of presentation to staff
21 <sup>st</sup> Sept 2005	Clonmel	Presentation to staff	Feedback of questionnaires
21 <sup>st</sup> Sept 2005	Cashel	Presentation to staff	Feedback of questionnaires
22 <sup>nd</sup> Sept 2005	WIT	General Manager	Discussion on the paper and the ways forward.
9 <sup>th</sup> Dec 2005	Clonmel	Executive Meeting & pre meeting with Integration Manager	Progress update
19 Jan 2006	Clonmel	Meeting with Integration Manager	Discussion on the accreditation process and their request for me to participate as a member of the leadership group
9 <sup>th</sup> February 2006	Clonmel	Accreditation Meeting STGH Meeting with General Manager and Integration Manager over lunch	Accreditation Progress updates
10 <sup>th</sup> February 2006	Clonmel	Executive Meeting	Review of progress and discussion on the mission statement for STGH.
6 <sup>th</sup> March 2006 (rescheduled from 2 <sup>nd</sup> March)	Waterford	Integration Manager	Discussion on Focus Group and objectives
21 <sup>st</sup> March 2006	Waterford	Integration Manager	Discussion on Focus Group and operation
11 <sup>th</sup> April 2006	Cashel & Clonmel	Research Assistant conducted focus groups (not present personally)	Focus group
13 <sup>th</sup> April 2006	Clonmel	General Manager	Discussion on the progress to date, the proposed timing of the amalgamation and the conducting of interview based data collection. Also discussion on the AOM paper and its joint presentation
29 <sup>th</sup> April 2006	Clonmel	General Manager	Review of operations
6 <sup>th</sup> June 2006		Presentation to Hospital Executive Management	Delivery of results on mission statement and suggestions for mission statements
6 <sup>th</sup> June	Clonmel	Integration Manager	Discussion on newsletter for mission statement

7 <sup>th</sup> July 2006	Cashel	Executive Group	Re-commencement of the executive group
28 <sup>th</sup> July 2006	WIT	General Manager	Discussion on the paper and workshop series for Atlanta Agreement of objectives of cycle 2.
4 <sup>th</sup> August 2006	Cashel	Executive	Meeting to review progress on progression specifically INO and Cashel action group
4 <sup>th</sup> August 2006	Cashel	General Manager	Brief meeting on the forthcoming conference in Atlanta to finalise (incl SPARC issues)
10 <sup>th</sup> August 2006	Atlanta	General Manager & conference groups	Presentation of paper and presentation of workshop
26 <sup>th</sup> Sept 2006	Clonmel	Meeting with General Manager & Integration Manager	Review of the progress & brief discussion on conference outcomes
9 <sup>th</sup> Oct 2006	Clonmel	Meeting with General Manager & Integration Manager	Discussed the key issues and the change targets. Pending target date to be announced by HSE as 12 <sup>th</sup> Jan for the amalgamation & how do we ensure that is achieved
12 <sup>th</sup> Oct 2006	Clonmel	Executive meeting	Discussed the pending announcement of the date and discussed the terms of reference of the group
17 <sup>th</sup> Oct 2006	-----	Phone conversation	Announcements of amalgamation by HSE
26 <sup>th</sup> October 2006	Clonmel	Executive Team Meeting	Progress reports
2 <sup>nd</sup> Nov 2006	Clonmel	Executive Team Meeting	Progress reports
9 <sup>th</sup> Nov 2006	Clonmel	Executive Team Meeting	Progress reports
23 <sup>rd</sup> Nov 2006	Clonmel	Executive Team Meeting	Progress reports
7 <sup>th</sup> Dec 2006	Clonmel	Executive Team Meeting	Progress reports
8 <sup>th</sup> Dec 2006	WIT	Meeting with Integration Manager	Discuss newsletter and state of process. Also review of the interviews and the operation of that
14 <sup>th</sup> Dec 2006	Clonmel	Executive Team Meeting	Progress reports
21 <sup>st</sup> Dec 2006	Clonmel	Executive Team Meeting	Progress reports
29 <sup>th</sup> Dec 2006	Clonmel	Executive Team Meeting	Progress reports
29 <sup>th</sup> Dec 2006	Clonmel	Meeting with Integration Manager, & follow on with General Manager	Review and broad discussion
3 <sup>th</sup> Jan 2007	Clonmel	Meeting with Integration Manager & Project Leader	Completing newsletter to inform on transfer Finalise final transfer arrangements and agree schedule of events for day
3 <sup>rd</sup> Jan 2007	Clonmel	General Manager	½ hour meeting to discuss



			preparation and next steps. Also discussed roles going forward
4 <sup>th</sup> Jan 2007	Clonmel	Executive Team Meeting	Review of scheduled activities created on the 3 <sup>rd</sup> .
4 <sup>th</sup> Jan 2007	Clonmel	Walk around site to see wards 1 week pre merger	See pre-merger state of hospital
11 <sup>th</sup> Jan 2007	Clonmel	Executive Team	Progress – final meeting pre merger
12 <sup>th</sup> Jan 2007	Clonmel	Site visit and walk around to all wards/ areas. Walked around with Integration Manager and with Director of Nursing	Arrived at 2.30 toward the end of the merger and saw the hospital in action as (the immediately new) STGH
18 <sup>th</sup> Jan 2007	Clonmel	Executive Team	1 <sup>st</sup> Review after merger
23 <sup>rd</sup> Jan 2007	Waterford (office)	Meeting with General Manager	Meeting to reflect
25 <sup>th</sup> Jan 2007	Clonmel	Executive Team	Ongoing Review after merger
23 <sup>rd</sup> March 2007	Waterford	Integration Manager	Update after several meetings had been cancelled
5 <sup>th</sup> April 2007	Clonmel	Meeting with the accreditation team	Preparation for the review of the hospital
18 <sup>th</sup> April 2007	Waterford (office)	Meeting with General Manager	Assess where we were 3 months post amalgamation
3 <sup>rd</sup> May 2007	Waterford (office)	Meeting with Integration Manager	Preparation for questionnaire/newsletter
11 <sup>th</sup> June 2007	Clonmel	Meeting with General Manager	Agreeing questionnaire/newsletter (short Meeting)
3 <sup>rd</sup> July 2007	Clonmel	Meeting with General Manager & Integration Manager	Finalising newsletter & launch of mission statement.
18 <sup>th</sup> June 2007	Clonmel	Launch of Mission Statement	Presentation to all Staff on mission statement
3 <sup>rd</sup> October 2007	Clonmel	Meeting with General Manager Integration Manager, and project manager	Discussion on presentation to be made the awards committee for a service award based on the amalgamation
4 <sup>th</sup> October 2007	Clonmel	Exec & Transfer groups (selection of staff)	Drafting and discussing presentation to be made to the awards committee for a service award based on the amalgamation
12 <sup>th</sup> November 2007	Clonmel	Presentations of questionnaire data to Staff	Reporting of findings to staff in two separate sessions
15 <sup>th</sup> January 2008	Clonmel	Meeting with General Manager	Discussion on Final feedback session (document presented)
15 <sup>th</sup> January 2008	Clonmel	Meeting with Integration Manager	Discussion on Final feedback session (document presented)
22 <sup>nd</sup> January 2008	Waterford	Reflection meeting with General Manager & Integration Manager	Final discussion session

## Appendix 4: Letter of Engagement for the Hospital Study

Ms. Breda Kavanagh,  
South Tipperary General Hospital,  
Clonmel,  
Co. Tipperary.

12 January 2004

RE: Amalgamation research project South Tipperary General -

Dear Ms. Kavanagh,

I am writing further to our recent correspondence and initial meeting of the 17<sup>th</sup> November 2003. Based on these discussions I would like to set out a memorandum of understanding in relation to the above research project. The purpose of this letter is to establish the spirit of the agreement and to define specific roles and responsibilities of the parties.

### *Context of Research*

As we discussed, the project is part of a doctoral research degree currently being taken at the University of Warwick. The doctorate examines how boundaries emerge and change during a merger and how they can be managed to maximise integration between the combining organisations. In relation to the work at South Tipperary General Hospital, the research will examine how boundaries emerge and change in the amalgamation of the Cashel and Clonmel hospitals as the amalgamation process develops. The timeframe for completion will be dependent on the timing of the amalgamation and is expected to be circa 6 months post the amalgamation date.

### *Roles & Responsibilities of the Researcher*

As researcher I acknowledge my obligations to South Tipperary General, its staff, patients and stakeholders, to conduct the research in accordance with the appropriate standards of ethics and within the accepted code of good research practice established individually by the University of Warwick, Waterford Institute of Technology and South Tipperary General Hospital. Specifically this includes;

1. Ensuring the security of all information designated as confidential;
2. Respecting privacy, confidentiality and anonymity of data sources as appropriate;



3. Affording the hospital the opportunity of reviewing the facts of the case and commenting or amending as appropriate, prior to any submission of the work for the award or for publication generally;
4. Adhere to all codes of practice established by the hospital.
5. Ensuring safe custody of all research materials collected as part of the research.

### ***Roles & Responsibilities of South Tipperary General***

South Tipperary General Hospital (STGH) acknowledge the purpose of the research as an academic process and endeavour to afford the researcher access to relevant information, materials, processes and research subjects as appropriate to the research degree. STGH reserve the right to refuse any request for information and further reserve the right to designate any piece of information as confidential where the release of that information into the public domain is deemed inappropriate by STGH.

### **Agreed Conditions**

1. STGH affirms its commitment to on-going learning and development and accordingly views research as a bi-directional activity that should improve practice at the hospital. In this respect a condition of agreeing to the research is that the Researcher serves as a member of the Executive Amalgamation Committee, in a non-executive advisory role, to advise on matters of amalgamation practice in line with existing and emerging theoretical frameworks. In addition it is expected that the researcher would conduct specific evaluations of the amalgamation on behalf of STGH. The researcher is entitled to expenses in respect of work conducted on behalf of STGH, as agreed from time to time.
2. Where the research requires interviews with staff members the researcher is required to submit details of the proposed research design, including details of the interview questions and to obtain clearance from the STGH's Ethics Committee before the conducting of the research.
3. STGH acknowledges that any intellectual property developed as part of the research process or analysis is the property of the researcher.
4. It is acknowledged that the research work will be submitted for academic publication and in this respect it is agreed that:
  - a. STGH will receive an advance copy of the publication, in so far as it relates to STGH.
  - b. STGH will be afforded an appropriate opportunity to request the amendment of any issues of fact or to question the inclusion of any information designatable as confidential. The right to analysis and comment remains with the researcher at all times.
  - c. STGH will have the right to anonymity and can demand that the work does not make reference to STGH and that STGH or any of its associates cannot be identifiable from the text of the publication.

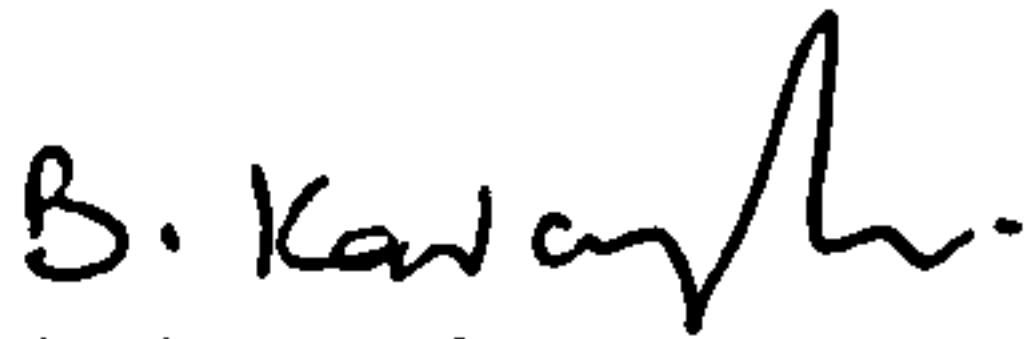
- 
5. STGH acknowledge that the work will be submitted for examination and viva-voice and as such may require the Researcher to discuss STGH as part of this examination process. For this situation STGH does not require the researcher to obtain prior approval for the discussion of the case in the examination process so long as the discussion is covered by an appropriate code of research conduct and the Researcher adheres to the rules of anonymity or confidentiality for any individual who has so requested or been promised.

I trust this memorandum of understanding reflects our discussions and would ask that you sight a copy of this letter and return it to me to formally record our agreement.

Yours sincerely,



Derek O'Byrne  
Researcher



Breda Kavanagh  
General Manager, South Tipperary General Hospital.

14/01/2004



## **Appendix 5: Ethical Clearance Application to HSE**

**Title: Longitudinal study of staff perceptions during the amalgamation of South Tipperary General**

### **The Research Project Team**

1. Lead researcher: Mr. Derek O'Byrne, Head of Strategic Planning, Waterford Institute of Technology
2. Two limited term research assistants (to be appointed)

### **The Hospital Contact Team**

1. Ms. Breda Kavanagh, General Manager, STGH.
2. Ms. Mary Burke, Integration Manager, STGH.

### **Statement of Research Objectives**

This research project is part of a wider research programme being conducted at South Tipperary General exploring how organisational boundaries change during a merger and how the management of boundaries can improve post-amalgamation integration.

The study aims to track the perceptions of staff about the boundaries that differentiate the two combining hospitals at two points in time approximately 2-3 months pre amalgamation and 2-3 months post amalgamation. The specific objectives are to identify

- a. How staff construct boundaries between the two units;
- b. How boundaries become salient in differentiating between hospital units;
- c. How perceived boundary conflicts are resolved;
- d. How boundaries change or shift over time.

### **The value of this research**

This is an important piece of work in the development of a boundary management model for organisational amalgamations. The conflict arising from a 'them' v 'us' attitude is a commonly recognised problem for merging organisations which often results in poor integration (physically, socially and culturally) of the merging organisations. Research further indicates that approximately 2/3rds of all mergers fail to achieve their objectives with poor integration being cited as a major cause of this failure<sup>1</sup>. Failure brings with it a number of negative consequences both in human and financial terms including the increase in associated work stress and increases in inefficient utilisation of organisational resource. To date however little focus has been paid to how merging units construct 'them' and 'us' and more importantly how that construction might be managed in practice. A number of theoretical perspectives shed some light on the types of issues that might be

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<sup>1</sup> For example, KPMG (2006) The Morning After: Driving for Post Deal Success. KPMG:Dublin

relevant and principle among these include a newly emerging field in boundary theory<sup>2 3 4</sup> and the application of social identity<sup>5</sup> approaches to organisational studies.<sup>6</sup>

The proposed research will directly address how boundaries divide ‘them’ from ‘us’ and accordingly the value of this research will be its contributions through;

- a. Increasing the understanding of how boundaries become salient in an amalgamation and how they create ‘them’ versus ‘us’ climates
- b. Creating a framework for managing boundaries in an amalgamation that will improve integration and accordingly reduce the negative consequences of integration problems
- c. Directly impacting the amalgamation of South Tipperary General Hospital through the creation of a cycle of reflection on the amalgamation process.
- d. Being the first longitudinal study in this specific discipline sub-field.

## Outputs of the Research

The primary use to which the research output will be put is to present the work for a PhD award at the University of Warwick. This thesis will generate a model for the management of boundaries in a merger. The contribution of this particular part of the research is to generalise to theory, developing and strengthening the emerging model.<sup>7</sup>

Consistent with academic scholarship it is anticipated that this will research will lead to formal academic publication in leading journals and conferences.

A final application of the research will be the benefit gained by South Tipperary General Hospital in applying and reflecting on the research model developed. The O’Byrne<sup>8</sup> model has already been used by the hospital in profiling the range of actions required and on-going reflection will improve practice in the long term.

## Outline of the methods to be used

The principal method of investigation will be the case study method<sup>9</sup> applied through structured interviews. Interviews will be conducted at two points in time approximately 3 months pre-amalgamation and 3 months post amalgamation. Ten staff from each of the Cashel and Clonmel sites (20 staff in total) will be

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<sup>2</sup>, O’Byrne, D. and D. Angwin. (2003). “Changing Sub-Unit Boundaries during a Merger.” *The Irish Journal of Management*. Vol. 24 No. 1..

<sup>3</sup> Paulsen, N., and T. Hernes, (2003). *Managing Boundaries in Organisations: Multiple Perspectives*. Hampshire, UK: Palgrave.

<sup>4</sup> O’Byrne, D. (2006-inpress). “M&A as Boundary Management.” In Angwin, D.N. (ed) *Images of Mergers and Acquisitions*. Oxford: Blackwell Publications.

<sup>5</sup> Tajfel, H & J.C. Turner (1986) “The Social Identity Theory of Intergroup Behaviour” In Worchel, S. & W.G. Austin. *The Psychology of Intergroup Relations*. Nelson Hall; Chicago

<sup>6</sup> cf. Hogg, M.A. and D.J. Terry (2001) *Social Identity Processes in Organizational Contexts*. Philadelphia; Psychology Press.

<sup>7</sup> O’Byrne (2006) & Angwin and O’Byrne (2003) op cit

<sup>8</sup> O’Byrne (2006) op cit

<sup>9</sup> Yin, R.K. (2003). *Case Study Research: Design and Method*. Sage Publications. Thousand Oaks: California.



interviewed at each time interval (each participant will therefore be interviewed twice). This gives a total of 40 interviews. Interviews will be scheduled to last a duration of approximately 1 hour and will be conducted by the contract research assistants under the direction of the lead researcher.

A case study protocol has been constructed (attached) and this identifies the approach that each interviewer will adopt and the exact questions that will be asked. All interviews will be taped and transcribed by the interviewer. The lead researcher will conduct the analysis of the data using Nvivo data analysis software.

## **Risks analysis**

The research is concerned with the opinions and perceptions of the participants in relation to their experiences in the amalgamation of South Tipperary General. No questions are being asked of a sensitive nature that might endanger, physically or emotionally, any participant nor is there any direct impact on the participant or their work. In this respect the research has low risks attached. However, the research design must consider the following as potential areas of risk to stakeholders in the research project:

- Ensuring valid informed consent from subjects;
- Potential ethical considerations or conflicts in respect of the role of the lead researcher as a non voting member of the executive amalgamation group;
- Ensuring confidentiality & anonymity for subjects;
- Management of the research assistants and the effective conduct of the research process;
- Maintaining data storage and security;
- Providing the subject with the right of comment or correction on facts recorded.

## **Informed consent**

Informed consent requires the subject to understand fully the process of the interview and the uses to which the data will be put. It is necessary for the interviewee to be fully informed and be capable of assessing the impact of the research on them. To ensure this occurs all potential subjects will be presented with a written outline of the research process explaining the research and their role in it. It will be clearly explained that they have the choice not to participate. All subjects will be asked to sign a declaration that they are giving an informed consent for their participation in the research. In addition prior to the commencement of the interview the interviewer will verbally reiterate the purpose of the research and indicate the position of the participant in it. The participant at that point will again be asked to consent and will be further advised that they can decide not to answer any question should they so wish or may withdraw from the interview at any point.

## **Role of the lead researcher**

The lead researcher is also part of the executive amalgamation committee (in an advisory capacity only) and in this respect it is important that no conflict of interest, real or perceived, emerges in the research process. This will be achieved through the distancing of the lead researcher from the interviewees. Trained research assistants will conduct all of the interviews using a predefined research protocol instrument. Names of interviewees will not be included on the recording or transcripts of interviews and all subjects will only be identified through anonymous codes.

The purpose of the research is to generate new theory that can be applied in practice. A condition of the research is that the Hospital benefits from this theory and that the hospital can enhance its amalgamation process as a result. A necessary condition of the research is therefore feeding back results of the theory development into the Hospital amalgamation process. This involves discussion at the theoretical level only and the Hospital management will not receive any direct feedback on the content of the interviews.

## **Confidentiality & anonymity**

All subjects will be offered the option of defining any comments as confidential in which case the data will not be quoted or used external to the interview in any way. It is not anticipated that the discussions should include any information that would require confidentiality.

To ensure anonymity the names of all subjects will be removed from the data records and all interviewees will be given as anonymous code names. The reporting of data will make no specific reference to any identifiable individual either directly or indirectly.

## **Managing Research Assistants**

Responsibility of the acts of research assistants lie with the lead researcher and the lead researcher must ensure that research assistants abide by the appropriate codes of conduct and codes of ethics. This will be achieved in a number of ways.

- All research assistants will be required to sign a non-disclosure agreement.
- A research protocol instrument will be used to define the exact conduct of the interview, the questions that will be asked and the assurances that must be given to the subjects.
- All research assistants will be trained in the application of the research protocol and will be instructed in the ethical behaviour required for good research practice.
- The research assistant will not be permitted to hold the data except under the supervision of the lead researcher and only then for the purposes of transcription.
- The lead researcher will constantly monitor the performance of the research assistants.



## **Data storage and security**

Data includes the recordings of the interviews, the transcripts (physical and electronic) of those interviews and the electronic means by which those interviews are analysed. All data will be maintained by the lead research in a secure environment that is not openly accessible by other people. All electronic copies will be maintained on a personal computer of the lead researcher and where possible all files will be password protected.

All files, paper and electronic, will be recorded in a way that ensures the anonymity of the respondents and this provides an additional level of security that personal interviews will not be identifiable.

## **Right to comment**

In line with good research practice, copies of the individual's interview transcripts will be offered to that interviewee to afford them an opportunity of correcting or clarifying any factual inaccuracies, requesting the deletion of any point or the addition of subsequent clarifications.

**Appendix 6: Ethical Approval Letter of Grant**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

Waterford Regional Hospital,  
Dunmore Road,  
Waterford,  
Ireland.

Telephone 051 848000  
Fax 051 848572

**Name & Address of applicant:**  
Mr. Derek O'Byrne  
Head of Strategic Planning  
Waterford Institute of Technology  
Waterford

**Name of REC:**  
Regional Research Ethics  
Committee  
Waterford Regional Hospital

**Title of Application:**  
"Longitudinal study of staff perceptions during the amalgamation of South Tipperary General"

**Date:** 14<sup>th</sup> June 2006

Dear Mr. O'Byrne,

The Ethics Coordinator for the Research Ethics Committee, HSE, South Eastern Area has reviewed the above application and can grant **expedited approval** for this study.

The expedited approval has been given following review of:

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| Application Form                  | <input type="checkbox"/>            |
| Research Proposal                 | <input checked="" type="checkbox"/> |
| Literature Review                 | <input checked="" type="checkbox"/> |
| Questionnaire/ Interview Schedule | <input checked="" type="checkbox"/> |
| Other supporting documentation    | <input checked="" type="checkbox"/> |

The above application will also be reviewed by the Research Ethics Committee, HSE, South Eastern Area at their next meeting on 19<sup>th</sup> June 2006. Any comments made at this meeting shall be communicated to you in writing.

Yours sincerely

Caroline Lamb, Ethics Coordinator  
Research Ethics Committee, Old School of Nursing, Waterford Regional Hospital  
Tel: 051 842026 E-Mail: [Caroline.Lamb2@maila.hse.ie](mailto:Caroline.Lamb2@maila.hse.ie)

**Appendix 7: Schedule of Interviews Hospital Study**



## Schedule of Interviews for Cashel based staff

Informant Number <sup>10</sup>	Area	Pre-merger Interview <sup>11</sup>	Post-merger Interview
Cashel #1 post - merger	Patient Care Management (2)		✓
Cashel #2 pre-merger	Patient Care Management (1)	✓	
Cashel #3 pre-merger	Care Assistant (1)	✓	
Cashel #3 post-merger			✓
Cashel #4 post - merger	Patient Care (2)		✓
Cashel #5 post-merger	Clinical Care		✓
Cashel #6 pre-merger	Care Assistant (2)	✓	
Cashel #6 post-merger			✓
Cashel #7 pre-merger	Patient Care (3)	✓	
Cashel #8 pre-merger	Patient Care (4)	✓	
Cashel #9 pre-merger	Administration	✓	
Cashel #10 pre-merger	Support	✓	
Cashel #11 pre-merger	Care Assistant (3)	✓	
Cashel #11 post-merger			✓
Cashel #12 pre-merger	Patient Care (1)	✓	
Cashel #12 post-merger			✓
Cashel #13 post - merger	Patient Care (5)		✓
Cashel #14 post - merger	Patient Care (6)		✓
Cashel #15 pre-merger	Patient Care (7)	✓	

<sup>10</sup> These numbers are assigned in random order so as to protect the identity of informants.

<sup>11</sup> Dates of interviews are not provided because they would facilitate identification of informants.

**Schedule of Interviews for Clonmel based staff**

<b>Name</b>	<b>Grade</b>	<b>Reference Pre-merger Interview</b>	<b>Reference Post-merger Interview</b>
Clonmel # 1 pre-merger	Support (1)	✓	
Clonmel # 1 post-merger			✓
Clonmel # 2 pre-merger	Patient Care (1)	✓	
Clonmel # 3 pre-merger	Administrator (1)	✓	
Clonmel # 4 pre-merger	Patient Care (2)	✓	
Clonmel # 2 post-merger			✓
Clonmel # 5 pre-merger	Administrator (2)	✓	
Clonmel # 3 post-merger			✓
Clonmel # 6 pre-merger	Patient Care (3)	✓	
Clonmel # 4 post-merger			✓
Clonmel # 7 pre-merger	Patient Care (4)	✓	
Clonmel # 5 post-merger			✓
Clonmel # 6 post-merger	Support (2)		✓
Clonmel # 8 pre-merger	Support (3)	✓	
Clonmel # 9 pre-merger	Clinical Care	✓	
Clonmel # 7 post-merger			✓
Clonmel # 8 post-merger	Administrator (3)		✓
Clonmel # 10 pre-merger	Patient Care (5)	✓	
Clonmel # 9 post-merger			✓



## **Appendix 8: Interview Protocol<sup>12</sup> for South Tipperary General Hospital**

### **Longitudinal study of staff perceptions during the amalgamation of South Tipperary General – protocol for research assistants**

#### **Preliminary Matters**

Commence the interview by welcoming the interviewee to the discussion.

Introduce yourself as (name) from the Centre for Management Research in Healthcare at Waterford Institute of Technology.

Provide the participant with a copy of the participation information sheet and state the purpose of the research as per the sheet.

Advise the participant that the interview will be recorded to allow for analysis. Any comments made however will remain strictly anonymous and the interviewee will not be identified in any analysis or on the transcript of the interview.

Advise the participant that the interview is not intended to seek any information of a confidential nature but if there are any comments that they would like to remain confidential they should advise you and that request will be honoured.

Advise the participant that they may request that the discussion ends at any time.

Ask the participant to confirm that they consent to continue.

Ask to commence recording. Show the recording off button to the participant and advise them that if they wish to turn off the recorder at any stage, that they may feel free to do so.

Tell the interviewee that the interview should last approx. 1 hour

Tell them that if they wish they will be sent a copy of the transcript and they will have an opportunity to comment, amend change or clarify any points they make.

---

<sup>12</sup> © Derek O'Byrne May 2006

## Stage 1: Pre-amalgamation Interviews

### Questions for the pre-amalgamation Interviews

Interviewer to state name, interview code and welcome individual.

#### 1. Opening question

- a. What is your opinion on this amalgamation?

#### 2. Perceived differences between Cashel/Clonmel

- a. What is it like to work for this hospital?
- b. What things distinguish or identify this hospital?
- c. What do you think ?
  1. will change as a result of the amalgamation?
  2. might change as a result of the amalgamation?
  3. wont change as a result of this amalgamation?
- d. What do you know about the (other hospital) and how they operate?
- e. If you where to compare the two hospitals what would you say are the
  1. main differences?
  2. similarities?

#### 2. Identity

- a. What does being a member of this hospital actually mean to you?
- b. Are there characteristics that make this hospital unique?
- c. What do you think being a member of the new combined hospital will be like?

#### 3. Perceptions of the process

- a. How much contact have you had with (the other hospital)?
  - i. (prompt for People/organisation/patients/services etc)
- b. How well informed do you feel about the amalgamation?
- c. How much do you know about the (other hospital)?

#### 4. Process to date

- a. What do you think has worked well, if anything, in preparing for this amalgamation?

#### 5. Model of differences

- a. Have a look at this list of areas of potential differences. How many do you think might actually exist between your hospital and (the other hospital)?
- b. Are there any differences omitted from this list?



## List of Potential Differences

The following is a list of potential areas where differences might exist between Our Lady's Hospital Cashel and St. Joseph's Clonmel. To what extent do you feel these differences might create conflict when the hospitals merge?

### Differences in

- the context of work i.e. terms and conditions of employment such as work times, holiday leave etc.
  - the range of services offered by each hospital
  - the layout and standard of premises and buildings
  - the team structure arising from alteration to the existing team structure (e.g. addition of a number of new staff into your work team)
  - computer systems or the introduction of new technology
  - the introduction of a new management team
- 
- the perceived level of personal commitment that an individual in each hospital gives to their work
  - how work is performed and tasks completed in each hospital
  - the way staff behave with and relate to one another in each hospital
  - the expectations of the patient in each hospital
- 
- what each hospital defines as important in running and managing a hospital effectively
  - the extent to which each group wants to accept the new group (Strong sense of affinity with the existing hospital and a strong desire to maintain that hospital)

## Stage 2: Post Amalgamation Interviews

### Questionnaire Set 2 – post amalgamation

#### 1. Opening question

- a. We are now 3 months after the amalgamation what is your opinion now on this amalgamation?

#### 2. Perceived differences between Cashel/Clonmel

- a. What is it like to work for this newly amalgamated hospital?
- b. What has changed as a result of the amalgamation?
- c. What is changing as a result of this amalgamation?
- d. Do you anticipate anything else changing in the future?
- e. What do you know about the (other hospital) now in the light of the last number of months post amalgamation?
- f. How different is it here to (*original hospital of heritage*)?

#### 3. Identity

- a. Do you feel part of the new STGH hospital?
- b. What does being a member of this new STG hospital actually mean to you?
- c. How do you think the new STGH compares to the old (*hospital of heritage*) ?
- d. Are there characteristics that make this new amalgamated hospital unique?

#### 4. Perceptions of the process

- a. Is the amalgamation running smoothly and what do you feel has worked well or worked poorly in the transfer of services?
- b. Broadly, to date has the amalgamation worked?
- c. How well integrated do you think the two hospitals are now?
  - i. Are there examples you can give to demonstrate that point?
- d. Are there issues that need to be addressed and if so what are they?

#### 5. Model of differences

- a. We showed you this list of areas of potential differences at the last interview. How many do you think might actually have created issues for the amalgamation?
- b. Are there any issues omitted from this list?
- c. Is this a useful way of seeing where problems existed when the two hospitals came together?
- d. What would you do differently?



## **List of Potential Differences**

The following is a list of potential areas where differences might exist between Our Lady's Hospital Cashel and St. Joseph's Clonmel. To what extent do you feel these differences might created conflict when the hospitals merged?

### **Differences in**

- the context of work i.e. terms and conditions of employment such as work times, holiday leave etc.
  - the range of services offered by each hospital
  - the layout and standard of premises and buildings
  - the team structure arising from alteration to the existing team structure (e.g. addition of a number of new staff into your work team)
  - computer systems or the introduction of new technology
  - the introduction of a new management team
- 
- the perceived level of personal commitment that an individual in each hospital gives to their work
  - how work is performed and tasks completed in each hospital
  - the way staff behave with and relate to one another in each hospital
  - the expectations of the patient in each hospital
- 
- what each hospital defines as important in running and managing a hospital effectively
  - the extent to which each group wants to accept the new group (Strong sense of affinity with the existing hospital and a strong desire to maintain that hospital)

## **Appendix 9: Questionnaire - Hospital Study administered in March 2005**

### **Questionnaire**

#### **Information on the Questionnaire**

Please answer all the questions as indicated.

This questionnaire is designed to gather feedback from staff on the progress of the amalgamation and the level of awareness and preparedness for the amalgamation. It seeks *your opinions* on a range of matters including communications, work values and the climate for change. There are no right or wrong answers.

*The Centre for Management Research in Healthcare and Health Economics at Waterford Institute of Technology is administering the questionnaire. All responses will be treated with strict anonymity.*

For further information or clarification of any issue please contact  
Derek O'Byrne at 051-302746 or email [dobyrne@wit.ie](mailto:dobyrne@wit.ie)



# Section 1

**This section is to assess the level of awareness about the amalgamation**  
Please state your opinion (by marking a circle around the appropriate number) as to whether you agree or disagree with each of the following statements.  
A score of 1 means that you completely disagree and a score of 7 means that you completely agree. The mid point (4) represents no opinion one way or the other.

Statement	Extent to which you agree 1 = Completely disagree 7 = Completely agree						
I am up to date on how the transfer of services is progressing	1	2	3	4	5	6	7
There is a general information overload with either too much information available or not enough time to understand it	1	2	3	4	5	6	7
The information I have received about the transfer of services is relevant to me	1	2	3	4	5	6	7
I would like to receive more information on the transfer of services	1	2	3	4	5	6	7
I am happy with the progress being made to date on the transfer of services	1	2	3	4	5	6	7
I have contributed to the groups or partnership committees working on the transfer of services	1	2	3	4	5	6	7
I would like to contribute to the groups or partnership committees working on the transfer of services	1	2	3	4	5	6	7
I believe the partnership process is working well	1	2	3	4	5	6	7
I understand the logic behind the transfer of services	1	2	3	4	5	6	7
I think progress on the transfer of services is too slow	1	2	3	4	5	6	7
I think the transfer of services will improve the services to patients	1	2	3	4	5	6	7
Yes, I am in favour of the transfer of services	1	2	3	4	5	6	7
I have accessed the information about the transfer of services that is available on the intranet	1	2	3	4	5	6	7
I am able to access the intranet on a regular basis to access the information available	1	2	3	4	5	6	7

## Section 2

This section asks for your opinion on the quality of the information you have received to date.

The following statements concern the quality of information that you have received on the amalgamation. Please circle the number that most closely represents the quality of the information that in your opinion you have received to date.

The information I have received has been								
Timely	1	2	3	4	-3	-2	-1	Untimely
Credible	1	2	3	4	-3	-2	-1	Not Credible
Accurate	1	2	3	4	-3	-2	-1	Not accurate
Adequate	1	2	3	4	-3	-2	-1	Inadequate
Complete	1	2	3	4	-3	-2	-1	Incomplete



### Section 3

This section asks for your opinion on the values that should be important for South Tipperary General.

The following table includes statement that might be included in the mission statement of South Tipperary General. From the list of the statements chose 5 statements that you opinion are the five most important statements to include in the mission statement and rank them in order, from 1 to 5, where 1 is the most important.

Statement	Rate the top 5 from 1 to 5 in order of importance
The hospital places the patient at the centre of all its activities and always ensure a quality care environment for the patient	
The hospital will ensure a quality work environment for the staff	
The hospital operates on the principle of partnership with key stakeholders including staff, patients and care organisations	
The hospital offers the widest range of patient care services to the South Tipperary region	
The hospital will provide an environment to enable all staff develop to the highest professional level and will provide a quality training environment for all staff	
The culture will be open and participative and will emphasises the contribution of the individual to the development of the hospital	
The hospital will use its resources in the most efficient and effective manner possible	
The hospital will provide a holistic, multi-discipline, evidence based approach to patient care	
The hospital provides a range of integrated services which lead to modern dynamic medical and surgical provision	
The hospital will provide equity and adequacy of access to all	
The hospital will maintain the dignity and respect of its patients, staff and stakeholders at all times	
Please include any statement you feel should be incorporated (if any)	

# Section 4

The following table lists values that might be important to a hospital. Please identify the 5 most important values for the *your current hospital*, and identify the values that in your *opinion* are the 5 most important that should be adopted for *South Tipperary General*. Rank the 5 values in each case from 1 to 5, where a ranking of 1 indicates the most important.

Values	To South Tipperary General	To St. Josephs, Clonmel
Professionalism: Behaving in a professional manner		
Hospital Individuality: Being regarded as unique		
Ethics: Concern for honesty and integrity of all employees in conducting company matters		
Creativity: Being imaginative and innovative in development of services		
Efficiency: Operating without wasting resources.		
Service Leadership: Being considered a leader in the field		
Quality of Service: Meeting patient needs quickly, friendly and without delay		
Stability: Maintaining the existing services over time		
Service to the Community: Concern for community at large		
Growth: Increase the size of the hospital and its range of services		
Low Staff Turnover: Low number of staff who leave the hospital		
High Morale: A positive feeling for all staff about hospital		
Employee Satisfaction: Happy to work in the hospital		
Survival: Staying in operation & maintaining the services that are currently provided		
Promote Learning: Encouraging professional development and education at all levels		
Reduce Costs: Maintain low overheads		
Open Communication: Ease of giving and getting information in the hospital. The importance of informal communication		
Wide service provision: Spreading operations as wide as possible.		
Equity: Equal access to services for all		
Scientific Principles: Applying modern scientific principles to work practice		
Hospital Profile: Successful public image of hospital.		
Empathy: Understanding others and dealing with patients and staff in a compassionate manner		
Improving Procedures: Looking for better ways of doing things.		
Team Orientation: Creating and fostering team work.		
Value for Money: Providing value in services.		



# Section 5

This section is to assess the level to which you feel part of the hospital community

Please state your opinion (by marking a circle around the appropriate number) on whether you agree or disagree with each of the following statements. A score of 1 means that you completely disagree and a score of 7 means that you completely agree. The mid point (4) represents no opinion one way or the other.

Statement	Extent to which you agree 1 = Completely disagree 7 = Completely agree						
I see myself as being from St Joseph’s Hospital, Clonmel	1	2	3	4	5	6	7
I am pleased to be a member of St Joseph’s Hospital, Clonmel	1	2	3	4	5	6	7
I feel strong ties with St Joseph’s Hospital, Clonmel	1	2	3	4	5	6	7
I identify with other members of St Joseph’s Hospital, Clonmel	1	2	3	4	5	6	7
Being a member of St Joseph’s Hospital is important to me	1	2	3	4	5	6	7
I see myself as being from South Tipperary General Hospital	1	2	3	4	5	6	7
I am pleased to be a member of South Tipperary General Hospital	1	2	3	4	5	6	7
I feel strong ties with South Tipperary General Hospital	1	2	3	4	5	6	7
I identify with other members of South Tipperary General Hospital	1	2	3	4	5	6	7
Being a member of South Tipperary General Hospital is important to me	1	2	3	4	5	6	7

# Section 6

This section asks about the work of St Josephs Hospital Clonmel and Our Lady’s Hospital Cashel.

Please state your opinion (by marking a circle around the appropriate number) on whether you agree or disagree with each of the following statements. A score of 1 means that you completely disagree and a score of 7 means that you completely agree. The mid point (4) represents no opinion one way or the other.

Statement	Extent to which you agree						
	1 = Completely disagree						
	7 = Completely agree						
There is little difference between the work done in Our Lady’s Hospital, Cashel and St Joseph’s Hospital, Clonmel	1	2	3	4	5	6	7
I don’t know what they do in Our Lady’s Hospital, Cashel	1	2	3	4	5	6	7
People are friendly in Our Lady’s Hospital, Cashel and are easy to work with	1	2	3	4	5	6	7
People are friendly in St Joseph’s Hospital, Clonmel and are easy to work with	1	2	3	4	5	6	7
I know people in Our Lady’s Hospital, Cashel	1	2	3	4	5	6	7
The culture in Our Lady’s Hospital, Cashel and St Joseph’s Hospital Clonmel is similar	1	2	3	4	5	6	7



**Section 7**

**This section is for your general opinion on the transfer of services**  
**Please answer the questions**

<p>My biggest fear with the transfer of services is .....</p>
<p>If I was managing the transfer of services I would .....</p>
<p>I have the following suggestions .....</p>

# General Information

This section asks general information about the respondent. Please tick the appropriate box.

*Please indicate your area of work*

Consultant	<input type="checkbox"/>	Administration	<input type="checkbox"/>
NCHD	<input type="checkbox"/>	Administration Management	<input type="checkbox"/>
Nurse	<input type="checkbox"/>	Support Staff	<input type="checkbox"/>
Nurse Management	<input type="checkbox"/>	Technical Services	<input type="checkbox"/>
Allied Health Professional	<input type="checkbox"/>		
Allied Health Management	<input type="checkbox"/>		

*Please indicate your age group*

Under 25	<input type="checkbox"/>
Between 25 and 35	<input type="checkbox"/>
Between 36 and 50	<input type="checkbox"/>
Between 51 and 60	<input type="checkbox"/>
Over 60	<input type="checkbox"/>

*your length of service*

Less than 1 year	<input type="checkbox"/>
Between 1 year and 3 years	<input type="checkbox"/>
Between 3 year and 7 years	<input type="checkbox"/>
More than 7 years	<input type="checkbox"/>

*How far do you live (approximately) from*

*Cashel*

Under 10 miles	<input type="checkbox"/>
Between 10 – 24 miles	<input type="checkbox"/>
Between 25 – 40 miles	<input type="checkbox"/>
Over 40 miles	<input type="checkbox"/>

*Clonmel*

Under 10 miles	<input type="checkbox"/>
Between 10 – 24 miles	<input type="checkbox"/>
Between 25 – 40 miles	<input type="checkbox"/>
Over 40 miles	<input type="checkbox"/>

If you wish to enter the draw for the holiday voucher please include your employee number

---

Thank you for your time in filling out this questionnaire. The results of the questionnaire will help to ensure that the amalgamation of services is as effective as possible.

Please place the completed form in the boxes provide in the Hospital.

Appendix 10: Questionnaire Hospital Study administered in May 2007



# Annual questionnaire on the development of hospital services

## Instructions

Please answer all the questions as indicated.

This questionnaire is designed to gather feedback from staff on the progress of the hospital and its activities. It seeks *your opinions* on a range of matters including communications, work values and the climate of the Hospital. There are no right or wrong answers.

All responses will be entered into a draw for a ‘week-end away’ voucher

*The Centre for Management Research in Healthcare and Health Economics at Waterford Institute of Technology is administering the questionnaire. All responses will be treated with strict anonymity.*

For further information or clarification of any issue please contact  
Derek O’Byrne at 051-302746 or email [dobyrne@wit.ie](mailto:dobyrne@wit.ie)

## General information

This section asks general information about the respondent. Please tick the appropriate box.

*Please indicate your area of work*

Consultant	<input type="checkbox"/>	Administration	<input type="checkbox"/>
NCHD	<input type="checkbox"/>	Administration Management	<input type="checkbox"/>
Nurse	<input type="checkbox"/>	Support Staff	<input type="checkbox"/>
Nurse Management	<input type="checkbox"/>	Technical Services	<input type="checkbox"/>
Allied Health Professional	<input type="checkbox"/>		
Allied Health Management	<input type="checkbox"/>		

*Please indicate  
your length of service*

Less than 1 year	<input type="checkbox"/>
Between 1 year and 3 years	<input type="checkbox"/>
Between 3 year and 7 years	<input type="checkbox"/>
More than 7 years	<input type="checkbox"/>

*I was initially employed by*

Our Lady’s	<input type="checkbox"/>
St Joseph’s	<input type="checkbox"/>
South Tipp General	<input type="checkbox"/>
St Michael’s	<input type="checkbox"/>

If you wish to enter the draw for the week-end away voucher please include your name and work location\_\_\_\_\_

Thank you for your time in filling out this questionnaire. The results of the questionnaire will help to ensure that hospital service are as effective as possible.

Please place the completed form in the boxes provide in the Hospital.

Section 1

This section is to assess the success of the amalgamation of services

Please state your opinion (by marking a circle around the appropriate number) as to whether you agree or disagree with each of the following statements.

A score of 1 means that you completely disagree and a score of 7 means that you completely agree. The mid point (4) represents no opinion one-way or the other.

Statement	<i>Extent to which you agree</i> <b>1 = Completely disagree</b> <b>7 = Completely agree</b>						
	Disagree			Agree			
The amalgamation of services at South Tipperary General has been successful	1	2	3	4	5	6	7
The transfer of services is now complete	1	2	3	4	5	6	7
I was well informed about the transfer of services and knew what to expect	1	2	3	4	5	6	7
The Hospital provides better services now than when the services were on separate sites	1	2	3	4	5	6	7
I am happy with the progress being made to date after the transfer of services	1	2	3	4	5	6	7
I feel I contributed to creating the new hospital	1	2	3	4	5	6	7
We operate as one hospital now rather than two separate hospitals	1	2	3	4	5	6	7
The staff from St Joseph's and Our Lady's Hospitals work together as a team	1	2	3	4	5	6	7
Our service continues to improve all of the time	1	2	3	4	5	6	7
We have achieved a high standard of service since the amalgamation	1	2	3	4	5	6	7
When problems or issues arise they are dealt with effectively	1	2	3	4	5	6	7



Section 2

This section asks for your opinion on the quality of the information you received.

The following statement concerns the quality of information that you received about the hospital. Please circle the number that most closely represents the quality of the information that in your opinion you have received to date.

Information I receive is:								
Timely	1	2	3	4	5	6	7	Untimely
Credible	1	2	3	4	5	6	7	Not Credible
Accurate	1	2	3	4	5	6	7	Not accurate
Adequate	1	2	3	4	5	6	7	Inadequate
Complete	1	2	3	4	5	6	7	Incomplete

Section 3

This section is to assess the level to which you feel part of the hospital community

Please state your opinion (by marking a circle around the appropriate number) on whether you agree or disagree with each of the following statements. A score of 1 means that you completely disagree and a score of 7 means that you completely agree. The mid point (4) represents no opinion one way or the other.

Statement	<i>Extent to which you agree</i> 1 = Completely disagree 7 = Completely agree						
I see myself as being from South Tipperary General Hospital	1	2	3	4	5	6	7
I am pleased to be a member of South Tipperary General Hospital	1	2	3	4	5	6	7
I feel strong ties with South Tipperary General Hospital	1	2	3	4	5	6	7
I identify with other members of South Tipperary General Hospital	1	2	3	4	5	6	7
Being a member of South Tipperary General Hospital is important to me	1	2	3	4	5	6	7

## Section 4

### This section assesses the work climate

Please state your opinion (by marking a circle around the appropriate number) on whether you agree or disagree with each of the following statements. A score of 1 means that you completely disagree and a score of 7 means that you completely agree. The mid point (4) represents no opinion one way or the other.

Statement	<i>Extent to which you agree</i> 1 = Completely disagree 7 = Completely agree						
I enjoy my work	1	2	3	4	5	6	7
I feel appreciated in my job	1	2	3	4	5	6	7
My views and my participation are valued	1	2	3	4	5	6	7
Morale is high in South Tipperary General Hospital (STGH)	1	2	3	4	5	6	7
Overall I am happy working at STGH	1	2	3	4	5	6	7
My manager is responding to the issues of most importance to me	1	2	3	4	5	6	7
STGH is a good place to work	1	2	3	4	5	6	7
STGH is a friendly place to work	1	2	3	4	5	6	7

## Section 5

### This section is for your general opinion on how services are developing

I would have the following comments and suggestions to enhance the quality improvement process in the hospital (if any)



Appendix 11: Templates for application of a boundary approach to merger integration

Table 1: Classifying Boundary Differences

Boundary Class/type	Description	Description	Differences and Comments
Physical Boundaries	Organisation 1	Organisation 2	
Work requirements			
Product set			
Location			
Team constitution			
Owners			
IT system			
Branch manager			
Behavioural Boundaries	Organisation 1	Organisation 2	
Personal Investment			
Work Processes			
Team Behaviour			
Customer Service			
Cognitive Boundaries	Organisation 1	Organisation 2	
Work Beliefs			
Belonging			

**Table 2: Action plan template with sample data from hospital study**

Planned Actions	Physical Boundaries	Behavioral Boundaries	Cognitive Boundaries
<i>Contact &amp; Awareness Building</i>	Staff exchanges Staff open days Integration Newsletter Partnership groups Staff briefing Manager led Information booth Integration manager appointed		
<i>Training &amp; Behavior Support</i>		Staff swap days Integration training days Task groups to determine work practices (partnership) On-going training	
<i>Building of a Vision</i>			Leader involvement at all levels Clear vision ' expressed Partnership Groups working on values Feedback mechanisms Open communication channels and dialogue  Redrafting of Mission Statement



## Appendix 12: Letter of Acknowledgement from STGH

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Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

HSE South,  
South Tipperary General Hospital,  
Clonmel,  
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Mr Derek O'Bryne  
Strategic Planning  
Waterford Institute of Technology  
Cork Road  
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13<sup>th</sup> February 2007

**Re Amalgamation of Acute Services, South Tipperary**

Dear Mr O'Byrne

In relation to the amalgamation of acute services on January 12<sup>th</sup> 2007, I wish to express my gratitude to you for the role you played in preparation for the amalgamation, and the follow up post transfer.

Your work has contributed to the success of the amalgamation, benefiting the people of the South Tipperary catchment area. I look forward to working with you in the future to build on the success of the amalgamation.

Yours sincerely

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Breda Kavanagh  
General Manager